

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 0467 CERTIFICATE OF DEATH

00457

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Carroll		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL - Finksburg	
Rural - Finksburg		3 1/2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Farel - Finksburg	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
William		THOMAS	ACKMAN
4. DATE OF DEATH		Month	Day
		Jan.	30
		1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	Aug. 6, 1882
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
		77	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Engineer		Western High School	Md.
12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John A. Ackman		Margaret Burns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		None	Myfortha Ackman - Finksburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
446 X		one week	
DUE TO		Uremic Coma	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Nephrosclerosis, Generalized arteriosclerosis (c) Chronic heart failure, Generalized edema	
DUE TO		years	
DUE TO		4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12.6.1960 to 1.30.1960, that (I) (we) last saw the deceased alive on 1.27.1960, and that death occurred on 1.30.1960, from the causes and on the date stated above.		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE San A. Okutman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1.30.60
22c. PHYSICIAN'S NAME (Type) San A. Okutman		22d. ADDRESS Sykesville Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-2-60	23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral
23d. LOCATION (City, town, or county) Baltimore, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Hight		ADDRESS Sykesville, Md.	25a. REC'D BY REGISTRAR DATE FEB 3 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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 death. Page 4
 res that the death certificate be executed within 24 hours
 signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR
may be retained by
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0468

CERTIFICATE OF DEATH

Reg. Dist. No.

00458

1. PLACE OF DEATH a. COUNTY CARROLL New Windsor		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland so r b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL		c. LENGTH OF STAY IN lb 9 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural R.D. 1 New Windsor					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 1		d. STREET ADDRESS R.D. 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GERTRUDE	First M.	Middle ALBERT	Last	4. DATE OF DEATH January 21	Month Year 1960				
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24 1891	9. AGE (In years last birthday) 68	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland, Frederick Co. U.S.A.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME David Glass			14. MOTHER'S MAIDEN NAME Cora Horton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	Address				
				Walter J. Albert	New Windsor R.D. 1 Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
<i>Arteriosclerotic Cardi-Vascular disease — years</i>									
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) New Windsor		(County) Md.	(State) Md.
21. I certify that I attended the deceased from 9/1/59 , 19, to 11/21/60 , 19, that I last saw the deceased alive on 1/8/60 , 19, and that death occurred at 7:00 PM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									DATE SIGNED 11/21/60
ACTUAL SIGNATURE <i>M. E. Robertson</i>		M.D. New Windsor M.D., 11/21/60							
PHYSICIAN'S NAME (Type) M. E. ROBERTSON M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25 1960		22c. NAME OF CEMETERY OR CREMATORIUM Linganore		22d. LOCATION (City, town, or county) Frederick County			
(State) Md.		(State) Md.			(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ		ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE JAN 27 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thrall</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0469

CERTIFICATE OF DEATH

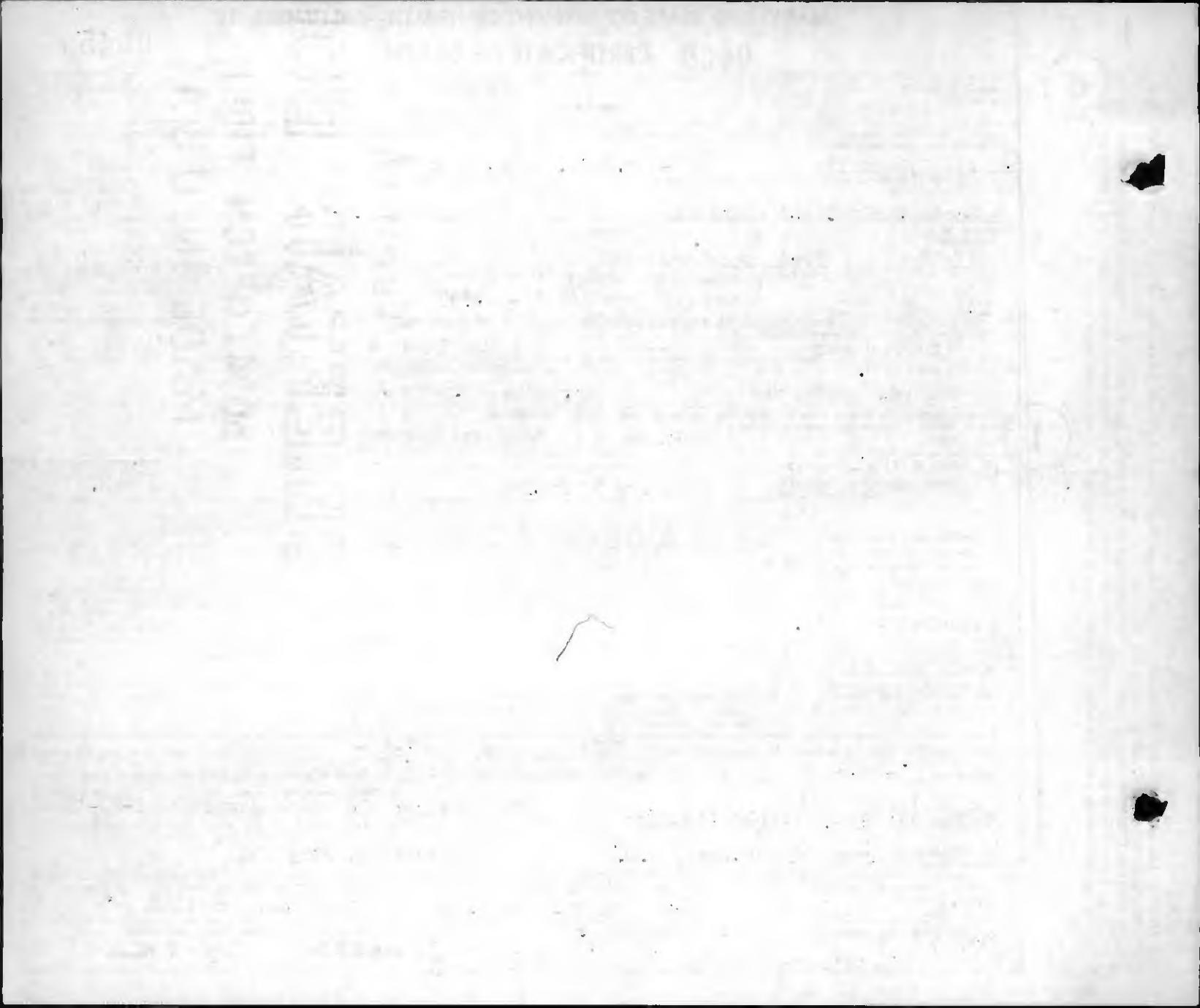
00459

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural) Sykesville		c. LENGTH OF STAY IN lb 22-5mo.21da.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
515		3401-4		
3. NAME OF DECEASED (Type or print) Ferdinand Arnreich		First J.	Middle Ferdinand	
Last Arnreich		4. DATE OF DEATH 1	Month 20	
5. SEX Male		Day 19	Year 60	
6. COLOR OR RACE White		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-1885	9. AGE (In years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fish business		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME M. Ferdinand Arnreich		14. MOTHER'S MAIDEN NAME Charlotte Augusta Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. unknown	INFORMANT Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 min.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General paresis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1953, 19, to 1-20-60, that I last saw the deceased alive on 1-20-60, 19, and that death occurred at 4:15 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1-20-1960		
ACTUAL SIGNATURE Myron Nizankowsky		M.D.		
PHYSICIAN'S NAME (Type) Myron Nizankowsky, M.D.		Sykesville, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/60	22c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cemetery	22d. LOCATION (City, town, or county) Woodlawn, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE W.M. J. Zichner & Sons		ADDRESS 71 Pa Aves 17	24a. REC'D BY REGISTRAR DATE JAN 22 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

100460

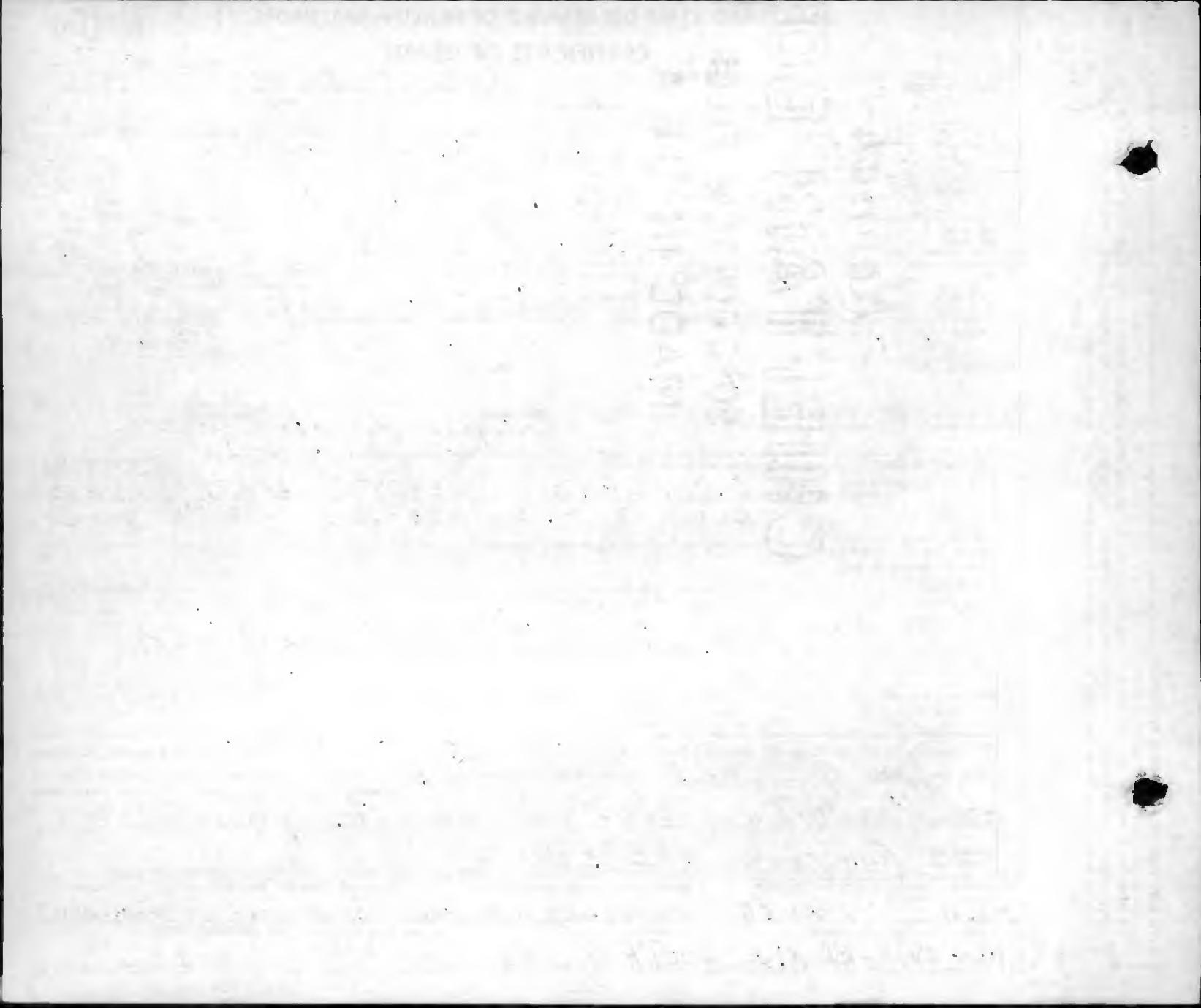
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		0420		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Carroll		MARYLAND		a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 5yr. 1mo 20d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Sykesville		Baltimore MD		3. STREET ADDRESS 1736 N. Port St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Springfield State Hosp					
3. NAME OF DECEASED (Type or print)		First Mary	Middle Victoria	Last ASKEW	4. DATE OF DEATH 1 - 9 Month Year 1960
5. SEX fem.		6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-1-1880	9. AGE (In years lost birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) No Caroline	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Outlaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		INFORMANT Springfield State Hosp. Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		CHRONIC ARTERIOSCLEROTIC HEART DISEASE years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO CORONARY ARTERIOSCLEROSIS DISEASE years			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIPTION OF INJURY OCCURRED (If not an accident, injury, or disease, check here) none			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) Oak St. Sykesville, Md.	(County) Baltimore (State) Maryland
21. I certify that I attended the deceased from alive on <u>Jan. 9</u> , 19 <u>60</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Oak St. Sykesville, Md.			
ACTUAL SIGNATURE Konstantin Weber		DATE SIGNED M.D.			
PHYSICIAN'S NAME (Type) Konstantin WEBER M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-12-60	22c. NAME OF CEMETERY OR CREMATORIAL MORELAND MEM. PARK		22d. LOCATION (City, town, or county) BALTIMORE (State) MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight Jr.		ADDRESS 6009 Harford Rd.		24a. REC'D BY REGISTRAR DATE JAN 13 '60	24b. REGISTRAR'S SIGNATURE Charles S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0452

CERTIFICATE OF DEATH

Reg. Dist. No.

00461

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN 1b 2 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 47 Frederick Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown	
3. NAME OF DECEASED (Type or print) Donald William		d. STREET ADDRESS 47 Frederick Street	
4. DATE OF DEATH January		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 14, 1908
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Aughinbaugh		14. MOTHER'S MAIDEN NAME Nora Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 173-03-0699 Mrs. Donald W. Auginbaugh, Taneytown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Artery Occlusion</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> <i>4/6x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Rheumatic Heart Disease (Chronic)</i> DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Acute Bronchitis, Chronic Lymphatic Leukemia.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/21</i> , 19 <i>60</i> , to <i>1/22</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1/22</i> , 19 <i>60</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. S. McVaugh</i>		ADDRESS (Street, city or town, state) M.D. <i>49 Frederick St.</i> <i>Taneytown, Md.</i>	
PHYSICIAN'S NAME (Type) <i>R. S. McVaugh M.D.</i>		DATE SIGNED <i>1/22/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF January 26 1960	
22c. NAME OF CEMETERY OR CREMATORIUM St. Joesph Cemetery		22d. LOCATION (City, town, or county) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Merwyn C. Fuss</i> C.O. Fuss & Son, Taneytown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>JAN 25 '60</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Meuse</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0471 CERTIFICATE OF DEATH

Reg. Dist. No. 00462

PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN lb

6Yr. 3Mo. 15Days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland.

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

433 East 85 th Street.

e. IS RESIDENCE
ON A FARM?

YES

NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
1-Day
31Year
1960

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

yrs.

10. UNDER 1 YEAR

IF UNDER 24 HRS

Female

White

WIDOWED DIVORCED

9-14-72

87

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Ezra Young

14. MOTHER'S NAME

Sabina

X Goldthorpe

Bollar

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown
If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

No

INFORMANT

Hospital Records

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

2 Hours

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

Arteriosclerotic Heart Disease

Years.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
CBS assoc. with disturbance of metabolism, growth or
nutrition with senile brain disease, with psychotic reaction
PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 10-16, 1953, to 1-31-, 1960, that I last saw the deceased
alive on 1-31, 1960, and that death occurred at 2-30P, from the causes and on the date stated above.ACTUAL
SIGNATURE

Irene Kamm M. D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S
NAME (Type)

Sykesville, Md.

22a. BURIAL, CREMATION,
REMAINS (if any)

Feb. 2. 1960

22c. NAME OF CEMETERY OR CREMATORIUM

Blue Ridge Cemetery

22d. LOCATION (City, town, or county)

(State)

Thurmont, Fred. Co

23. FUNERAL DIRECTOR'S SIGNATURE

Raymond E. Crager

ADDRESS

Thurmont, Md.

24a. REC'D BY REGISTRAR

DATE FEB 2 '60

24b. REGISTRAR'S SIGNATURE

Cuthbert & Kamm



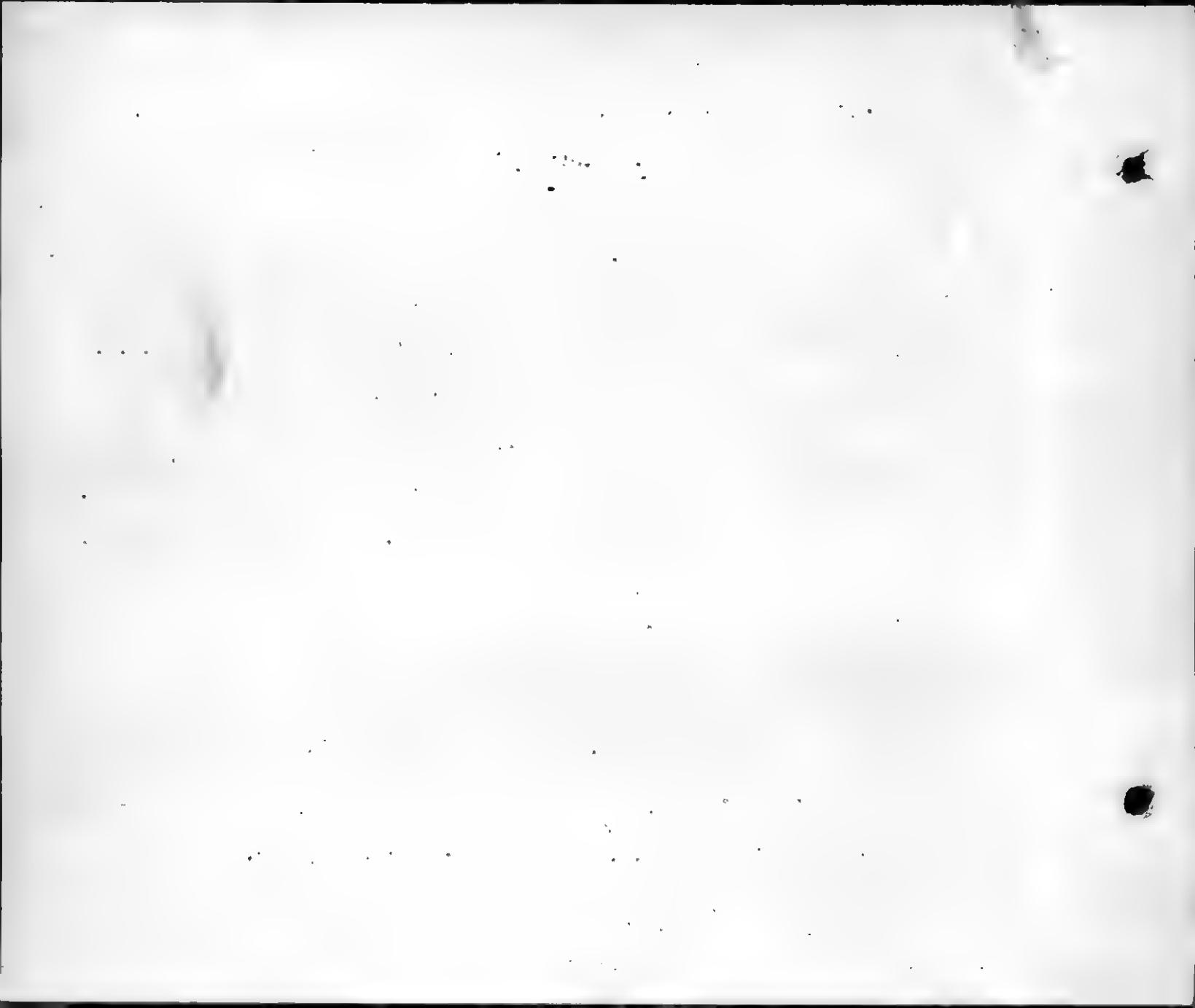
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0472 CERTIFICATE OF DEATH

Reg. Dist. No.

00463

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 13 yrs. 9 mos. 4 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First John	Middle H.	Last Barncord	
4. DATE OF DEATH	Month January	Day 3,	Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Barncord		14. MOTHER'S MAIDEN NAME Martha Gomer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO INFORMANT Springfield Hospital Records		
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Years.		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenia, paranoid type.		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month Doy. Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1955, to January 3, 1960, that I last saw the deceased alive on January 3, 1960, and that death occurred at 10:10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 1/4/60
ACTUAL SIGNATURE Agustín del Campo	M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustín del Campo, M.D.	Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1-8-60	22c. NAME OF CEMETERY OR CINERARY Baltimore Cemetery	22d. LOCATION (City, town or county) Baltimore, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE James V. Kennedy, Sykesville, Md.	ADDRESS	24a. REC'D BY REGISTRAR JAN 12 '60	24b. REGISTRAR'S SIGNATURE Charles S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0473 CERTIFICATE OF DEATH

Reg. Dist. No.

00464

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Delroy		First Middle Last Bell	4. DATE OF DEATH 1 24 Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-31-1937
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Brooks Bell		14. MOTHER'S MAIDEN NAME Hennie Boggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nearine Mouzone - Same as patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Far advanced pulmonary tuberculosis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 8, 1960, to January 24, 1960, that I last saw the deceased alive on January 24, 1960, and that death occurred at 10:10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edgars M. Maculans, M.D. PHYSICIAN'S NAME (Type)			
ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 1-24-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-60	
22c. NAME OF CEMETERY OR CREMATORIAL Establishment		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE George E. Maculans		23d. ADDRESS 1348 North Henryton	
24a. REC'D BY REGISTRAR JAN 27 '60		24b. REGISTRAR'S SIGNATURE C. Lee S. Turner	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0474 CERTIFICATE OF DEATH

Reg. Dist. No.

00465

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pleasant Valley		c. LENGTH OF STAY IN b Life				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pleasant Valley				
3. NAME OF DECEASED (Type or print) Carrie		First Blanche	Middle Black			
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH April 11, 1874			
8. ADDRESS Housework		9. AGE (In years lost birthday) 85 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home				
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Edward M. Hahn		14. MOTHER'S MAIDEN NAME Laura Devilbiss				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	INFORMANT Mr. Edward M. Black, Westminster, Md. R.D.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 10 days ago				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO arterio-aneurysm		and 50 years				
(c) seizure						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none				
20c. TIME OF INJURY Hour a.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white of work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Westminster	(County) Md.	(State) Md.
21. I certify that I attended the deceased from Jan. 5, 1960 to Jan. 5, 1960 that I last saw the deceased alive on Jan. 4, 1960 , and that death occurred at 12 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Westminster, Md.		DATE SIGNED 1-6-60		
ACTUAL SIGNATURE C. J. Billings		PHYSICIAN'S NAME (Type) C. J. Billings/ea				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 8, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cemetery	22d. LOCATION (City, town, or county) Pleasant Valley, Maryland	(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss	ADDRESS Taneytown, Maryland	24a. REC'D BY REGISTRAR John 8 '60	24b. REGISTRAR'S SIGNATURE Orville S. Knapp			

10000
10000

6. *Leucosphaera* *gigantea*
R. B. M. B.
P. 112

10000

9. *Leucosphaera* *gigantea* R. B. M. B.
10000 10000
10000 10000
Leucosphaera *gigantea*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0475 CERTIFICATE OF DEATH

Reg. Dist. No. 00466

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 7 mos. 15d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 9404 Kingsley Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 9404 Kingsley Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ANTHONY	Middle B.	Last BORZI	4. DATE OF DEATH January	Month 3	Day 19	Year 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 11-12-1870	9. AGE (In years lost birthday) 89 yrs.	10. UNDER 1 YEAR Months 21	11. UNDER 24 HRS Hours 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant -Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy			
13. FATHER'S NAME Paolo Borzi				14. MOTHER'S MAIDEN NAME Maria Grazia Borzi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-46-8824A		INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH Days 471X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with senile brain disease, with psychotic reaction 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May 18</u> , 1959, to <u>January 3</u> , 1960, that I last saw the deceased alive on <u>January 3</u> , 1960, and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Agustín del Campo</i>		M.D. Springfield State Hospital 1-4-60					
PHYSICIAN'S NAME (Type) Agustín del Campo		Sykesville, Maryland					
22a. BURIAL, CREMAT. ON REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-6-60	22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cem.		22d. LOCATION (City, town, or county) Silver Spring, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pennington</i>		ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR DATE JAN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

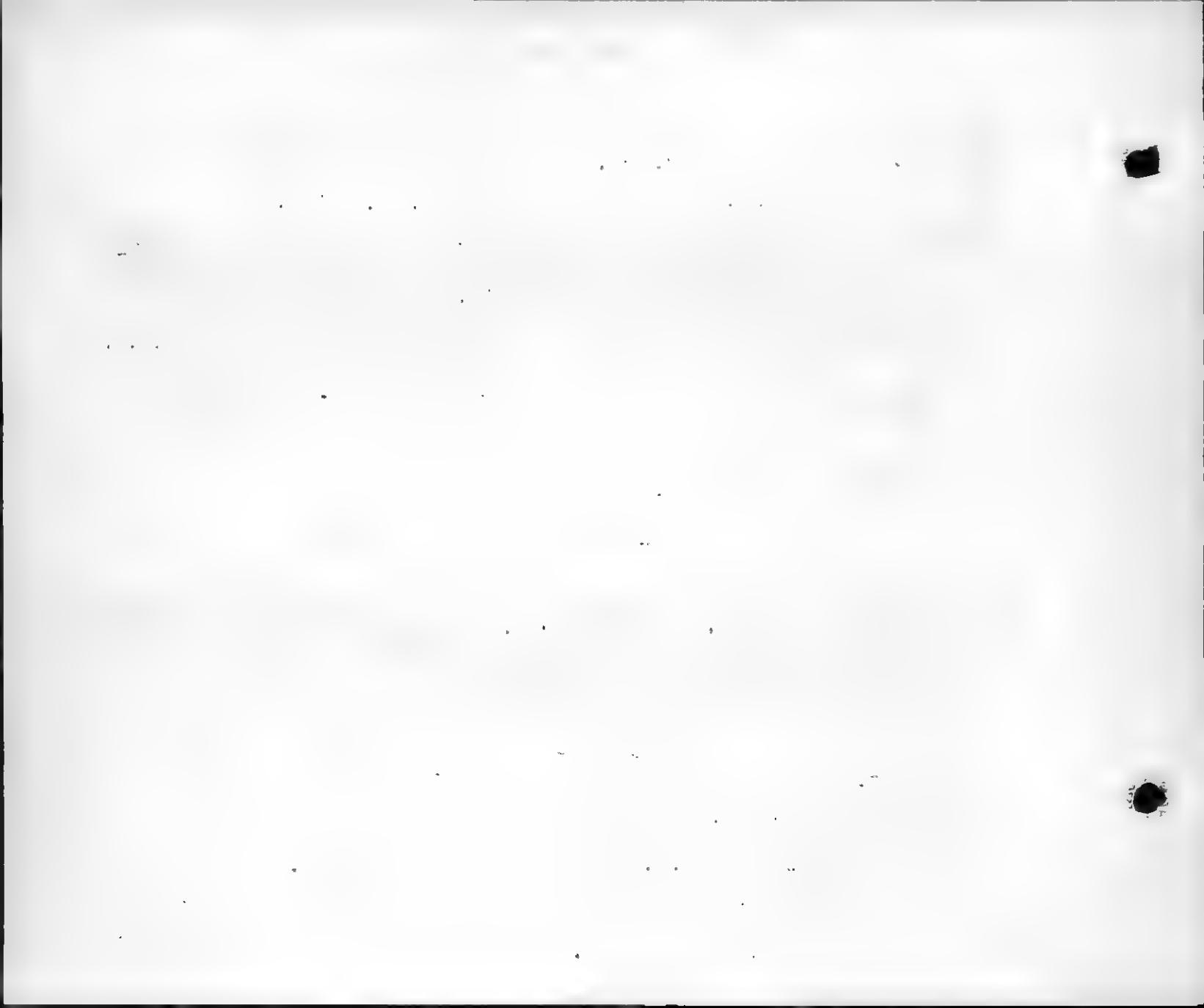
0476

CERTIFICATE OF DEATH

Reg. Dist. No.

00467

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 15 Yr. 3 Mo. 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) Lavinia		d. STREET ADDRESS 217 E. North Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-1874
9. AGE (In years last birthday) 85	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mathias Roop	14. MOTHER'S MAIDEN NAME Katherine Vogel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT Hospital records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriolosclerotic Heart Disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 5 Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile psychosis, simple deterioration.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-24-44, 19____, to 1-31, 1960, that I last saw the deceased alive on 1-31, 1960, and that death occurred at 3-50a.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE Ilse Kamm		ADDRESS (Street, city or town, state) Sykesville, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 1-31-60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7 Set 1960	
22c. NAME OF CEMETERY OR CEMETORY Baltimore Park Cem		22d. LOCATION (City, town or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Coulson		24a. ADDRESS 7309 Washington Blvd	
24b. REC'D BY REGISTRAR FEB 3 '60		24c. REGISTRAR'S SIGNATURE Charles S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0403 CERTIFICATE OF DEATH

Reg. Dist. No. 00468

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		b. COUNTY Carroll	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Taneytown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 313 East Baltimore Street		d. STREET ADDRESS / 313 East Baltimore Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carrie		First Elizabeth	Middle Brown
4. DATE OF DEATH January 29, 1960		Last	Month Day Year
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH January 16, 1900	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William G. Myers		14. MOTHER'S MAIDEN NAME Fannie Harman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mr. Tobias O. Brown, Taneytown, Md.	
17. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Cardio-Vascular Disease 14 yrs (c) Essential Hypertension 16 yrs		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Cholecystitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 17, 1955</u> , to <u>Jan 28, 1960</u> , that I last saw the deceased alive on <u>Jan. 27, 1960</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE E. Ambler Thompson, M.D.		DATE SIGNED 1/29/60	
PHYSICIAN'S NAME (Type) E. Ambler Thompson		Taneytown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 1, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Merle F. Fuss		ADDRESS C.O. Fuss & Son, Taneytown, Md.	
24a. REC'D BY REGISTRAR FEB 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Lewis	



21

FOR STATE
HEALTH DERT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

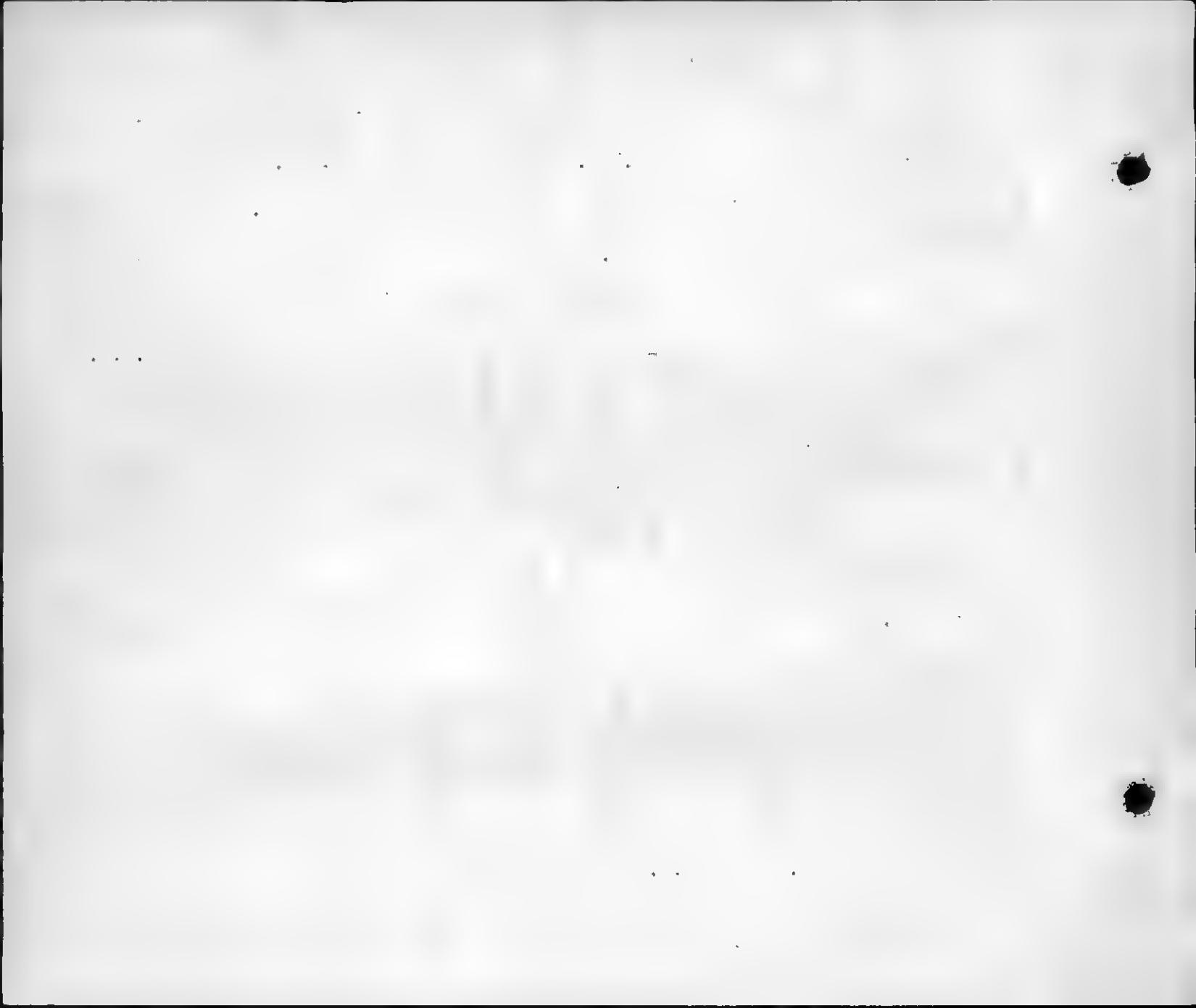
06463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 30 yrs. 1 mo. 24 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 2022 Rayner Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md.		d. STREET ADDRESS		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Edward		First H.	Middle .	Last Brown	4. DATE OF DEATH January 12, 1960	Month Year	Day Year	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN	8. DATE OF BIRTH 9. AGE (In years from birthday) 66 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	11. KIND OF BUSINESS OR INDUSTRY —	12. BIRTHPLACE (State or foreign country) Maryland	13. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown JOHN H BROWN		14. MOTHER'S MAIDEN NAME Unknown JOAN JONES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. —		17. INFORMANT Springfield Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paresis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE James T. Marsh		23. EXAMINER'S NAME (Type) James T. Marsh, M.D.		24. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/12/60					
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/60		22c. NAME OF CEMETERY OR CREMATORIAL SAMS CREEK		22d. LOCATION (City, town, or county) CHARROLL C. 110		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Hartzell & Sons New Windsor, Md.		24a. ADDRESS 11 Hartzell & Sons New Windsor, Md.		24b. REC'D BY REGISTRAR JAN 20 '60		24c. REGISTRAR'S SIGNATURE Arthur S. Kraus									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

FUNERAL DIRECTOR: File Pages 1 and 2 with the State Board of Health. File Page 3 as a burial-transit permit. File Pages 1 and 2 with any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0478 CERTIFICATE OF DEATH

Reg. Dist. No. 00470

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u> 2 WKS.		c. LENGTH OF STAY IN 1b <u>2 WKS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEADOWVIEW CONV. HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOWARD HENRY</u>	First <u></u>	Middle <u>Brown</u>	4. DATE OF DEATH Month <u>JANUARY</u> Day <u>17</u> Year <u>1960</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 8 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED, TOBACCO SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>D. JOSHUA BROWN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH BANKERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>MRS. CHAS. F. MAGEE, WESTMINSTER, MD.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC PYELONEPHRITIS</u> DUE TO (c) <u></u>		3 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20f. (City or town) (County) (State)</u>	
21. I certify that I attended the deceased from <u>OCTOBER 1952</u> to <u>JANUARY 17 1960</u> , that I last saw the deceased alive on <u>JANUARY 14 1960</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Stewart,</u>		ADDRESS (Street, city or town, state) <u>19 RIDGE R.D.</u> DATE SIGNED <u>1/17/60</u>	
PHYSICIAN'S NAME (Type) <u>William L. STEWART, M.D.</u>		WESTMINSTER, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN. 20, 60</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>KRIDERS CEMETERY RURAL WESTMINSTER, MD.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr., Westminister, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Calvin S. Myers</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0479 CERTIFICATE OF DEATH

Reg. Dist. No. 08471

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Sykesville		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural Finksburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Nursing Home				d. STREET ADDRESS / Deer Park Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First John	Middle Henry	Last Conaway	4. DATE OF DEATH January	Month 2	Day 19	Year 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1879	9. AGE (In years from birthday) 80	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME William Conaway		14. MOTHER'S MAIDEN NAME Catherine Schafer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 216-24-9806		17. INFORMANT Mrs. Lillie P. Conaway		Address Finksburg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 443 X		HYPERTENSIVE CARDIOVASCULAR DISEASE with X						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. X		ARTERIOSCLEROSIS, GENERALIZED X				20 yrs		
		(c) ARTERIOSCLEROTIC HEART DISEASE				20 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 21 April 1959, to 2 January 1960, that I last saw the deceased alive on 1 January 1959, and that death occurred at 2:00 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. H. Lawson Jr.</i>						ADDRESS (Street, city or town, state) Liberty Road at Eldersburg		
PHYSICIAN'S NAME (Type) H. Lawson, Jr., M.D.						DATE SIGNED 1.2.60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-4-60		22c. NAME OF CEMETERY OR CREMATORIUM Providence Cemetery		22d. LOCATION (City, town, or county) Gamber, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR JAN 5 '60		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0480

CERTIFICATE OF DEATH

Reg. Dist. No.

00472

TO HOSPITAL OR
HOSPITAL OR
may be retained
TO ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 227 Broadway, Balto. #31, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) PERRY		First	Middle	Last	4. DATE OF DEATH CROSS	Month	Day	Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/22/02		9. AGE (In years last birthday) 57	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Punch Press Operator		10b. KIND OF BUSINESS OR INDUSTRY Steel Industry		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lewis Cross				14. MOTHER'S MAIDEN NAME Mary Ferguson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-6179		INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure								
443 X DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Hypertensive cardio-vascular disease								
DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, chronic undifferentiated type.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/14/59 , 19____, to 1/1/60 , 19____, that I last saw the deceased alive on 1/1/60 , 19____, and that death occurred at 2:10 P.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
ACTUAL SIGNATURE <i>Agustini del Campo</i>		ADDRESS (Street, city or town, state) Sykesville, Maryland						
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 1/1/60						
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/60	22c. NAME OF CEMETERY OR CREMATORIAL Moreland Park, Inc.		22d. LOCATION (City, town, or county) 2905 Taylor Ave Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lowman		ADDRESS 900 Hollins St.	24a. REC'D BY REGISTRAR JAN 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0481 CERTIFICATE OF DEATH

Reg. Dist. No.

08473

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL		c. LENGTH OF STAY IN lb YEARS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARSTON		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL				
3. NAME OF DECEASED (Type or print) ELRITH ISABELLE DEVILBISS		4. DATE OF DEATH Month JAN Day 5 Year 1960	5. STREET ADDRESS MARSTON			
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH FEB 29-1880	9. AGE (In years lost birthday) 79 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	10c. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME ABRAHAM		14. MOTHER'S MAIDEN NAME ELLEN GORSUCH	12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONL	17. INFORMANT DONALD BOWERSOX NEW WINDSOR MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic Cardio-Vascular (INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) disease (c) Years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. 19	Month 1 Year 1960	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) New Windsor	(County) Carroll	(State) MD
21. I certify that I attended the deceased from 1/5/59 , 19, to 1/5/60 , 19, that I last saw the deceased alive on 1/4/60 , 19, and that death occurred at M , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)	DATE SIGNED 1/5/60	
ACTUAL SIGNATURE M. E. Robertson	PHYSICIAN'S NAME (Type) M E ROBERTSON					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/8/60	22c. NAME OF CEMETERY OR CREMATORIUM ST JAMES	22d. LOCATION (City, town, or county) Carroll Co MD (State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. Hartzler		ADDRESS 7200 New Windsor, Md	24a. REC'D BY REGISTRAR DATE JAN 8 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Evans		



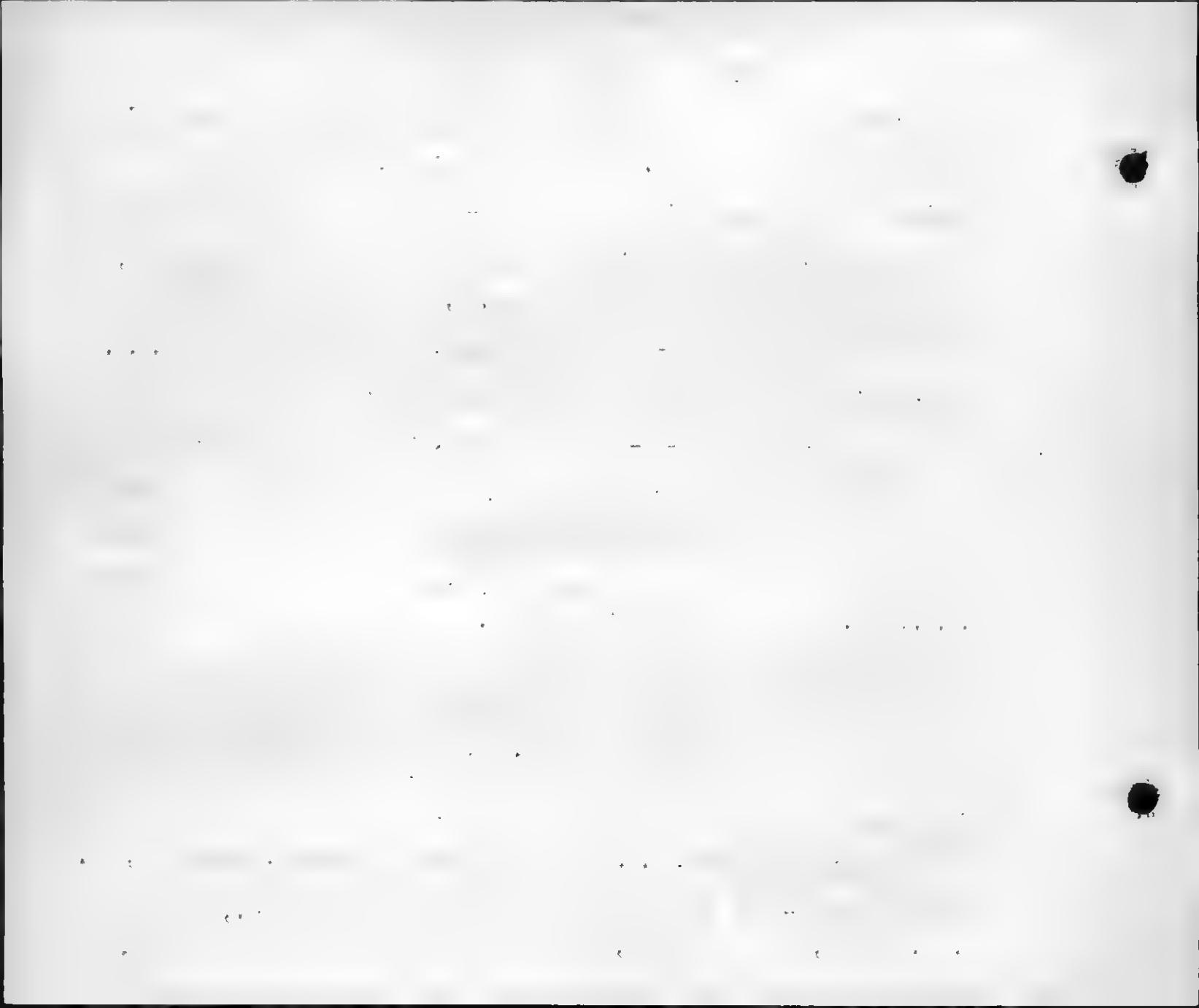
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send to the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00474

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2mos. 5days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
3. NAME OF (Type or print) James Blaine Easton		4. DATE OF DEATH Month Day Year January 19, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY - - -	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Easton		14. MOTHER'S MAIDEN NAME Sarah Shipley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-01-6557	
17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, lost. (b) Coronary artery thrombosis			
DUE TO			
(c) Arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) C.B.S. assoc. with cerebral arteriosclerosis.			
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1959 to January 19, 1960 , that (I) (we) last saw the deceased alive on January 18, 1960 , and that death occurred at 6:50 A.M. the causes and on the date stated above.			
22a. SIGNATURE <i>Agustin del Campo</i> 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22b. DATE SIGNED 1/19/60	
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-21-1960	
23c. NAME OF CEMETERY OR CREMATORIAL Ebenezer		23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		25a. ADDRESS Winfield, Maryland	
		25b. REC'D BY REGISTRAR DATE JAN 21 '60	
		25c. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00475

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived b. STATE MARYLAND) If institution, Residence before admission b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 139 CITY VIEW AVE.		d. STREET ADDRESS 139 CITY VIEW AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GILBERT REESE EBAUGH	First GILBERT	Middle REESE	Last EBAUGH		
4. DATE OF DEATH JANUARY 20 1960	Month JANUARY	Day 20	Year 1960		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 10 1908		
9. AGE (In years from birth) 51 yrs.	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS. Days 1	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST	10b. KIND OF BUSINESS OR INDUSTRY MILL WORK	11. BIRTHPLACE (State or foreign country) CARLTON MARYLAND U.S.A.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME JOSEPH ALLEN EBAUGH	14. MOTHER'S MAIDEN NAME STELLA REESE	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 216-03-9193	17. INFORMANT Wife - MRS. GILBERT EBAUGH - WESTMINSTER	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 5 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19 RIDGE RD.	20f. (City or town) WESTMINSTER, CARROLL, MD.	(County) WESTMINSTER	(State) MARYLAND
21. I certify that I attended the deceased from OCTOBER 1954 to JANUARY 20 1960 , that I last saw the deceased alive on JANUARY 16 1960 , and that death occurred at 4:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 19 RIDGE RD.					
ACTUAL SIGNATURE <i>William L. Stewart</i>	M.D. WESTMINSTER, MD.			DATE SIGNED 1/20/60	
PHYSICIAN'S NAME (Type) WILLIAM L. STEWART, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/23/60	22c. NAME OF CEMETERY OR CREMATORIUM LEISTER'S CEMETERY	22d. LOCATION (City, town, or county) WESTMINSTER, CARROLL, MD.	(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James G. Saffell Jr.</i>	ADDRESS WESTMINSTER	24a. REC'D BY REGISTRAR 25 60	24b. REGISTRAR'S SIGNATURE <i>John E. Knapp</i>		



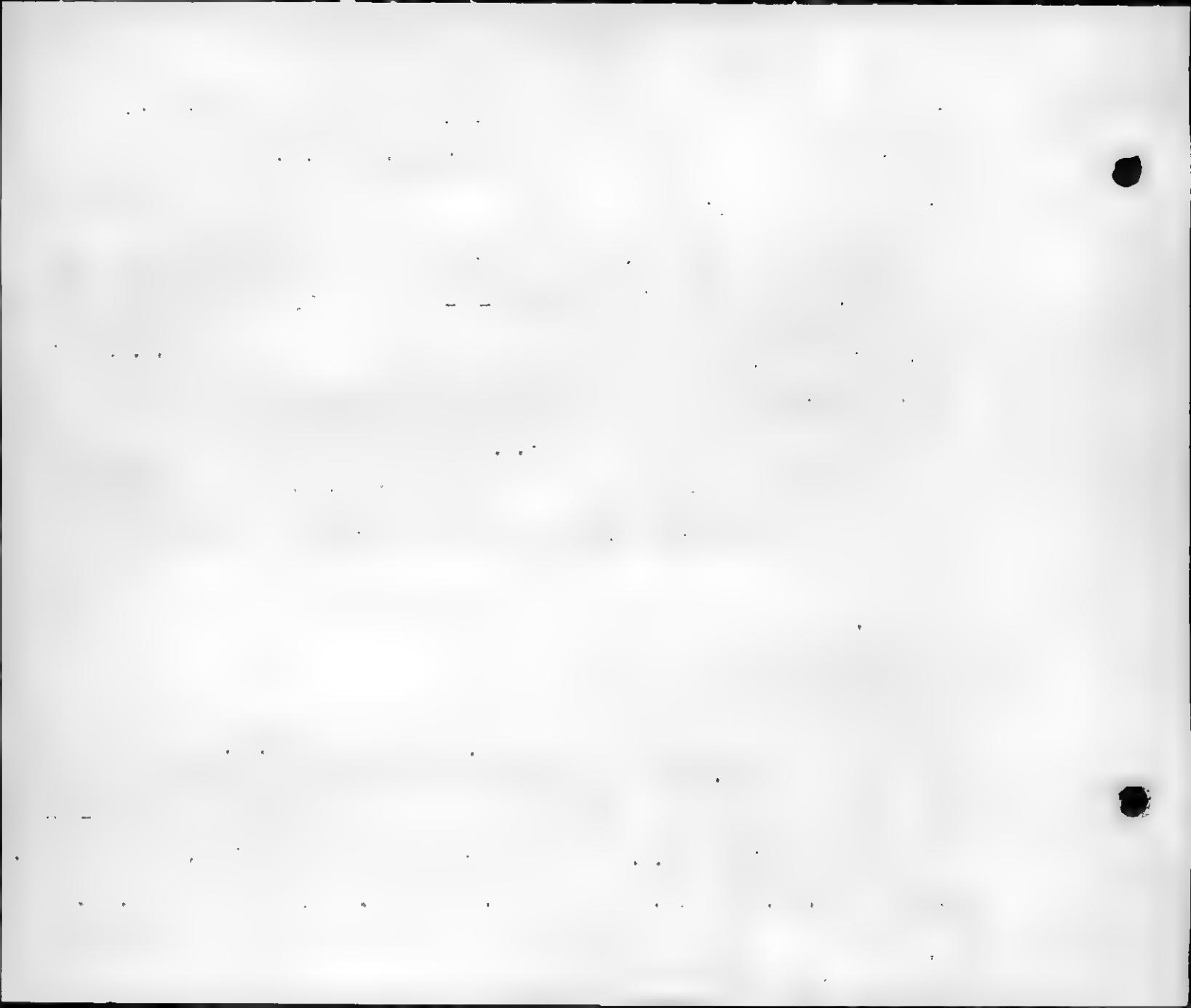
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0483

CERTIFICATE OF DEATH

00476

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 m 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg		d. STREET ADDRESS RdDI 10X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print)		First Anna	Middle Isabelle	Last Eckenrode	4. DATE OF DEATH 1 16 1960	Month 1	Day 16	Year 1960	
5. SEX Fem		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-83		9. AGE (In years last birthday) 76 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Eckenrode		14. MOTHER'S MAIDEN NAME Margaret Roddy				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT S.S. Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 41a. / Thrombosis of Right external iliac artery DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 22. SIGNATURE Edmund Lusthaus		years	
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield State Hospital, Sykesville, Md.	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		23a. BURIAL, CREMATION ON REMOVED <input type="checkbox"/> Jan. 20. 1960		23b. DATE THEREOF Jan. 20. 1960		23c. NAME OF CEMETERY OR CREMATORIUM St. Anthony Cem.		23d. LOCATION (City, town, or county) N.R. Emmitsburg Fredk. Co. MD	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont MD		25a. REC'D BY REGISTRAR DATE JAN 19 '60		25b. REGISTRAR'S SIGNATURE Carter S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0484

CERTIFICATE OF DEATH

Reg. Dist. No. 00477

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Henryton		c. LENGTH OF STAY IN 1b 1,548 days		b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 202 N. Greene Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alexander		Middle Felder		4. DATE OF DEATH Month January 22 Day 60 Year 1960	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-26-30		9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Manning, South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Willie Felder		14. MOTHER'S MAIDEN NAME Christien Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT Address Alexander Felder	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Due to (c) Far advanced bilateral pulmonary tuberculosis					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 27, 1955</u> to <u>January 22, 1960</u> , that I last saw the deceased alive on <u>January 22, 1960</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>Edgars M. Maculans, M.D.</u> DATE SIGNED ACTUAL SIGNATURE <u>Edgars M. Maculans</u> 1-22-60 PHYSICIAN'S NAME (Type) <u>Edgars M. Maculans, M.D.</u> Henryton State Hospital, Henryton, Md.					
22a. FUNERAL CREMATION 22b. DATE THEREOF 23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie Felder</u>		22c. NAME OF CEMETERY OR CREMATORIUM 23. ADDRESSES <u>Henryton State Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Manning, S.C.</u>	
24a. REC'D BY REGISTRAR DATE JAN 25 '60		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00478

CERTIFICATE OF DEATH

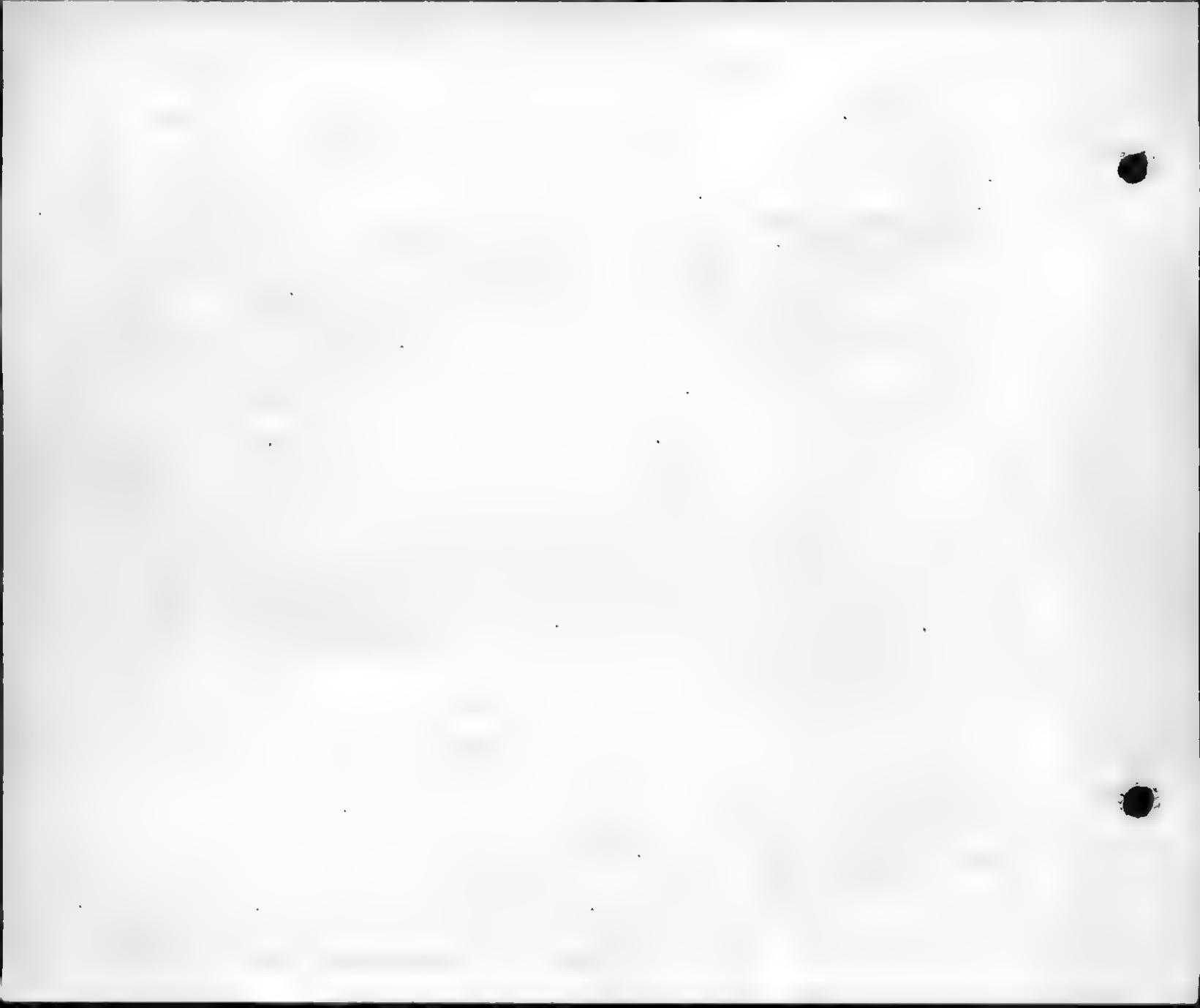
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived—If institution, Residence before admission) a. STATE	
<i>Baltimore</i> MARYLAND		<i>Maryland</i> Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 3 yrs	
<i>Manchester</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upperco</i> R. S. 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Conv. Home</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>WIRITH - IRENE - Fowble</i>			Last
4. DATE OF DEATH		Month	Jan.
		Day	18
		Year	1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>W</i>		<i>W</i>	<i>9-17-1874</i>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min
		<i>85 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Retired</i>		<i>Huck</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Md</i>		<i>WPA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>William Fowble</i>		<i>Susan Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>710</i>	
17. INFORMANT		Address	
<i>Mrs Rendle Cole - Hampstead Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Arteriosclerotic Heart Disease</i>	
420.0 DUE TO		<i>3 yrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Hydrocephalus at kidney & Semle Dementia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 1950</i> , 19 <i>60</i> , to <i>Jan 18</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan 18</i> , 19 <i>60</i> , and that death occurred at <i>5 p. m.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>W.H. Fowble</i>		<i>1-19-60</i>	
PHYSICIAN'S NAME (Type) <i>W.H. Fowble MD.</i>		<i>Manchester, Md</i> 1-19-60	
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-21-60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Grace Mott</i>		22d. LOCATION (City, town, or county) <i>Baltimore Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar G. Lipton</i>		ADDRESS <i>Hampstead Md</i>	
24a. REC'D BY REGISTRAR DATE <i>JAN 21 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

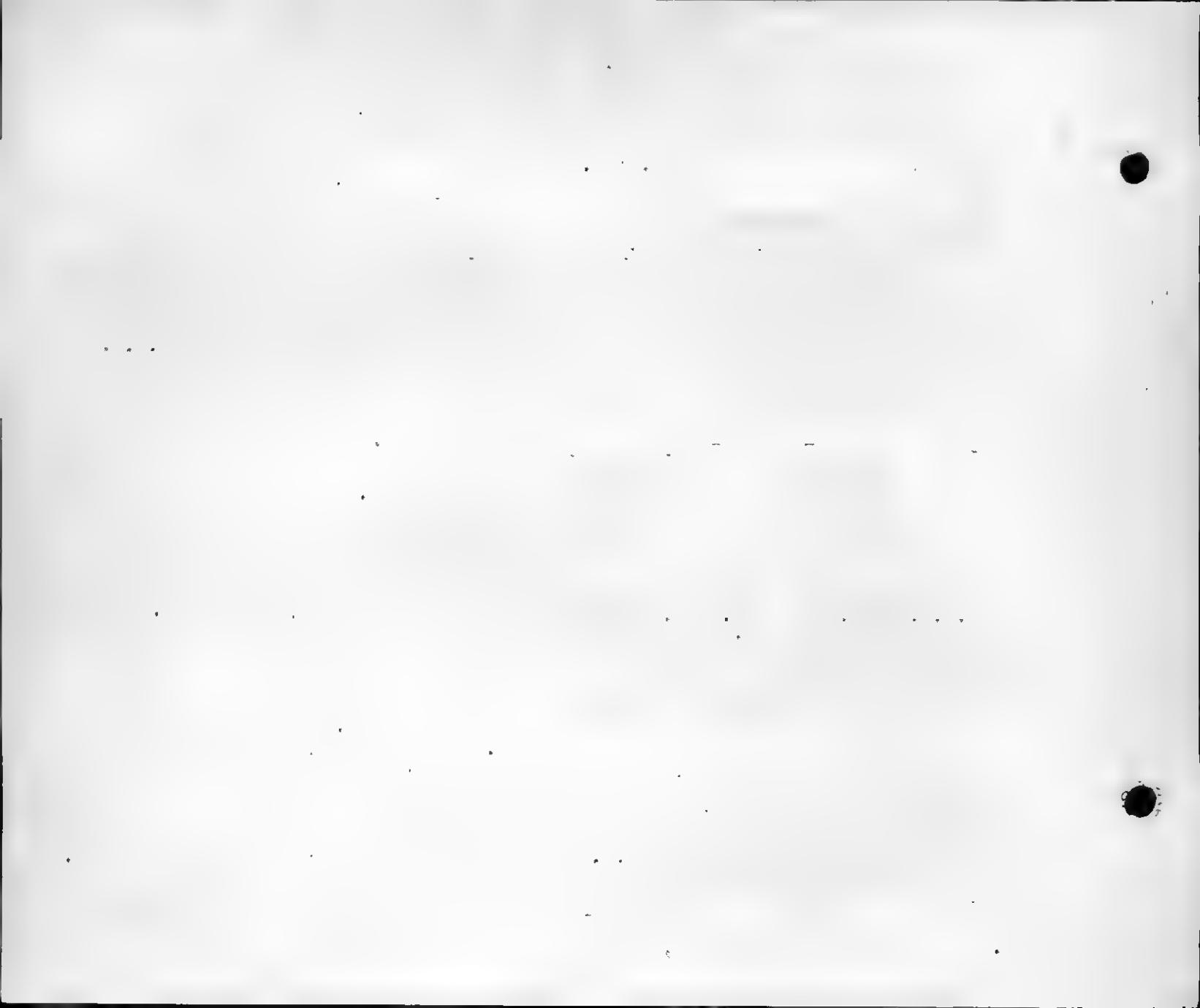


TO HOSPITAL OR The low requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in one envelope, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 0485 CERTIFICATE OF DEATH

00473

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE	
Carroll		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN lb lyrs. mos. day	
Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS RFD #1, 10 A,	
Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Ellen	Last Fuller
4. DATE OF DEATH	Month January	Day 29	Year 19 60
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 15, 1866
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical nurse		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Francis Fuller		14. MOTHER'S MAIDEN NAME Ella Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. INTERVAL BETWEEN ONSET AND DEATH Years 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b). DUE TO (b) (c)			
C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 28, 1955, to January 29, 1960, that (I) (we) last saw the deceased alive on January 28, 1960, and that death occurred at 8:30 AM from the causes and on the date stated above.			
22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 1/29/60	
Edmund Lusthaus, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/1/60	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	25a. REC'D BY REGISTRAR DATE FEB 2 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

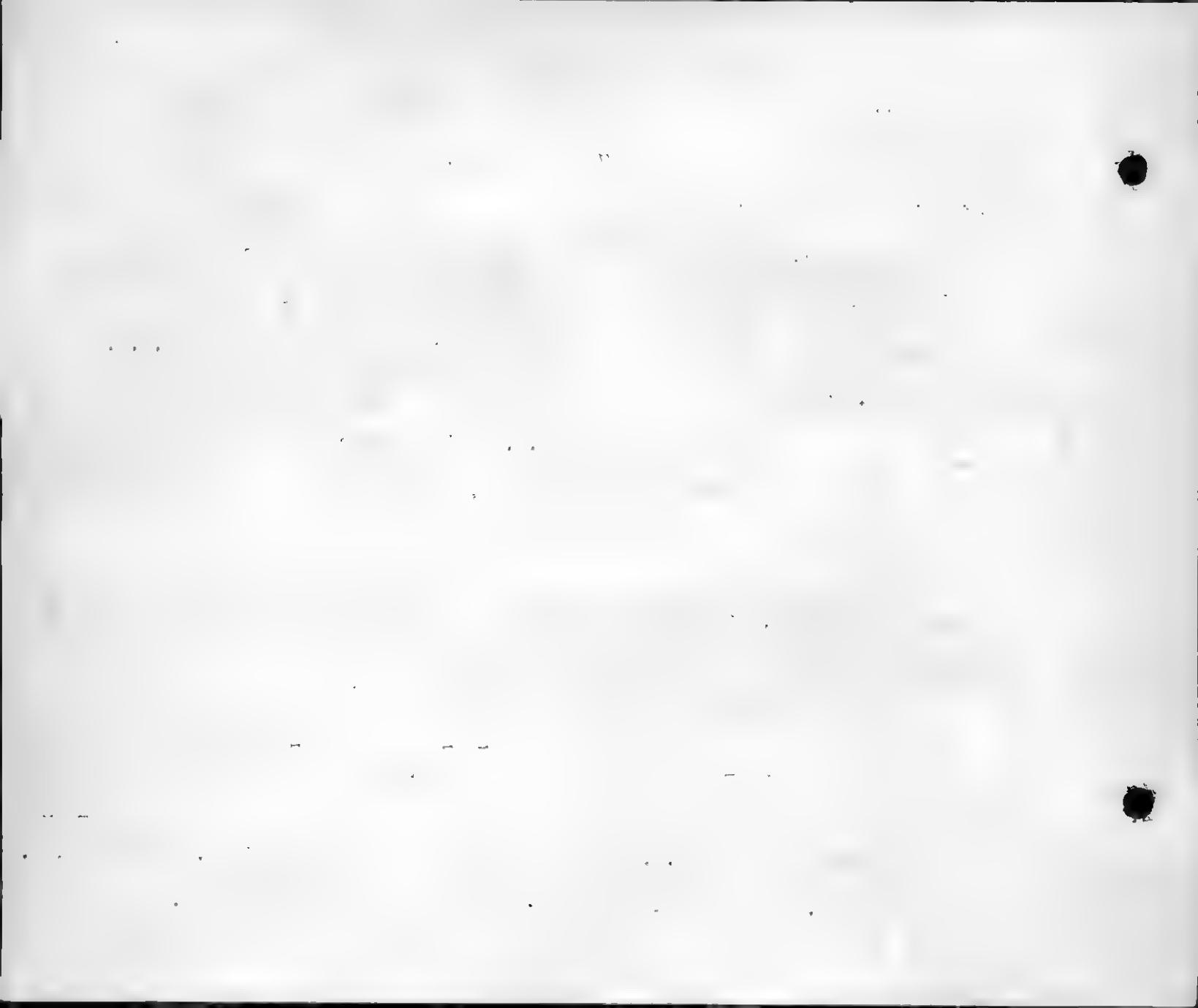
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0486

CERTIFICATE OF DEATH

00486

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15 y 5m 17 days		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Allegany	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank		First Monroe		Middle Gannon		4. DATE OF DEATH 1 23 19 60	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/24/27		9. AGE (In years last birthday) 32 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John R. Gannon		14. MOTHER'S MAIDEN NAME Gladys Gannon		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unkn		17. INFORMANT S.S. Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, far advanced				DUE TO 002 X				INTERVAL BETWEEN ONSET AND DEATH years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b)				DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental deficiency, without psychosis								19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) 10-20- 1954	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-23- 1960 , and that death occurred at 1:30PM from the causes and on the date stated above.									
22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.		22b. DATE SIGNED 1-23-60					
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 26, 1960		23c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		23d. LOCATION (City, town or county) Cumberland, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Right		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 26 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause			

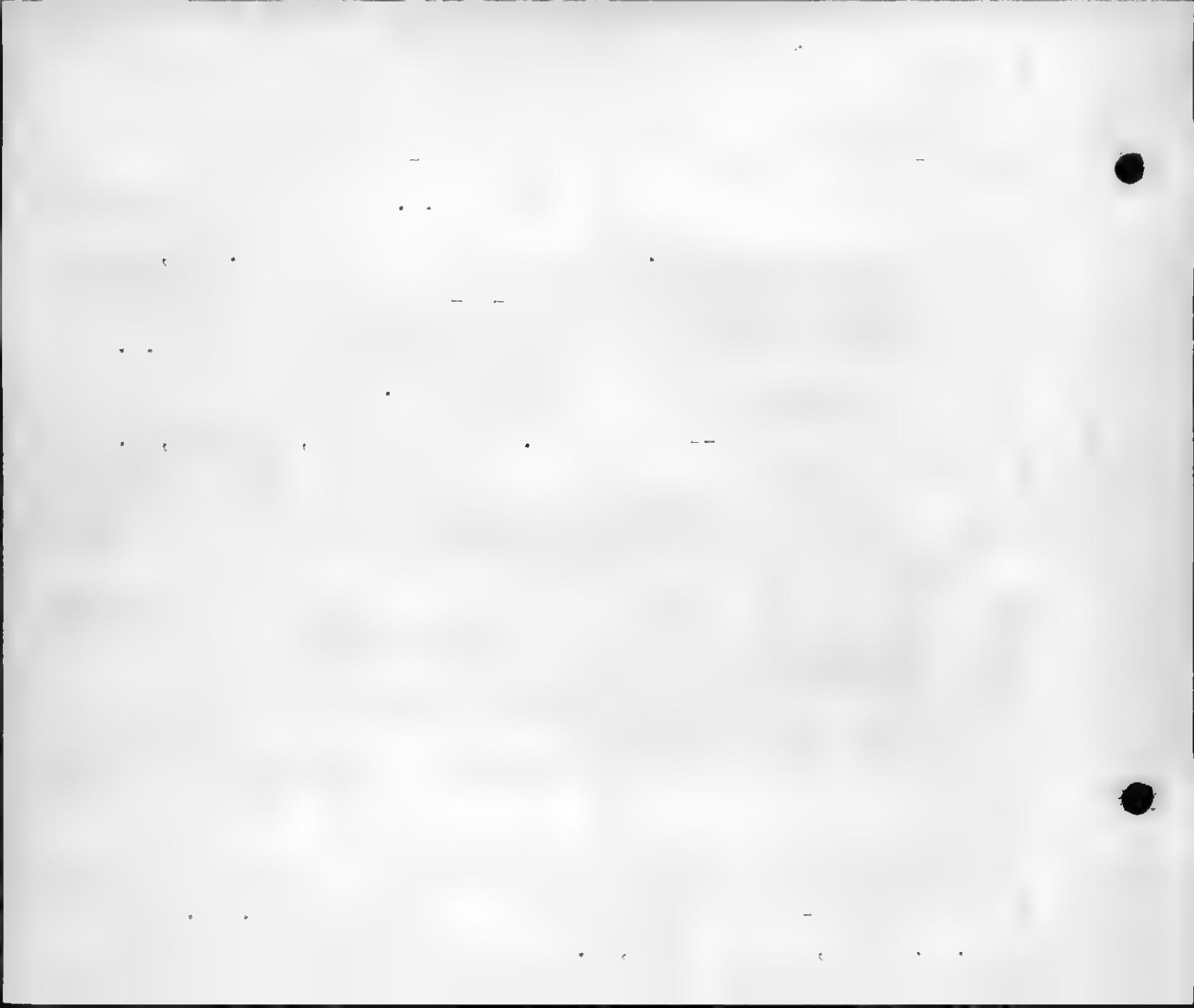


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0481 CERTIFICATE OF DEATH

Reg. Dist. No. **00481**

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville	
3. NAME OF DECEASED (Type or print) KATIE		First E.	Middle GIST
4. DATE OF DEATH Month JAN.	Day 7,	Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1880
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James Linton		14. MOTHER'S MAIDEN NAME Annie M. Frost	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. -----	17. INFORMANT Mrs. Herbert Latton, Damascus, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) Cerebral Hemorrhage 1957 with Partial Paralysis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Hour a. m. p. m.	Month Jan.	Day 19	Year 1960
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Winfield	(County) Carroll
21. I certify that I attended the deceased from June 15, 1957, to Jan 7, 1960 that I last saw the deceased alive on June 15, 1957 and that death occurred at Winfield , Md., from the causes and on the date stated above. ACTUAL SIGNATURE Morrell L. Martin M.D.		ADDRESS (Street, city or town, state) Winfield, Md. DATE SIGNED Jan 7-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-9-1960	22c. NAME OF CEMETERY OR CREMATORIAL Wesley Freedom	22d. LOCATION (City, town, or county) Carroll Co., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	24a. REC'D BY REGISTRAR DATE JAN 11 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Trahan



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

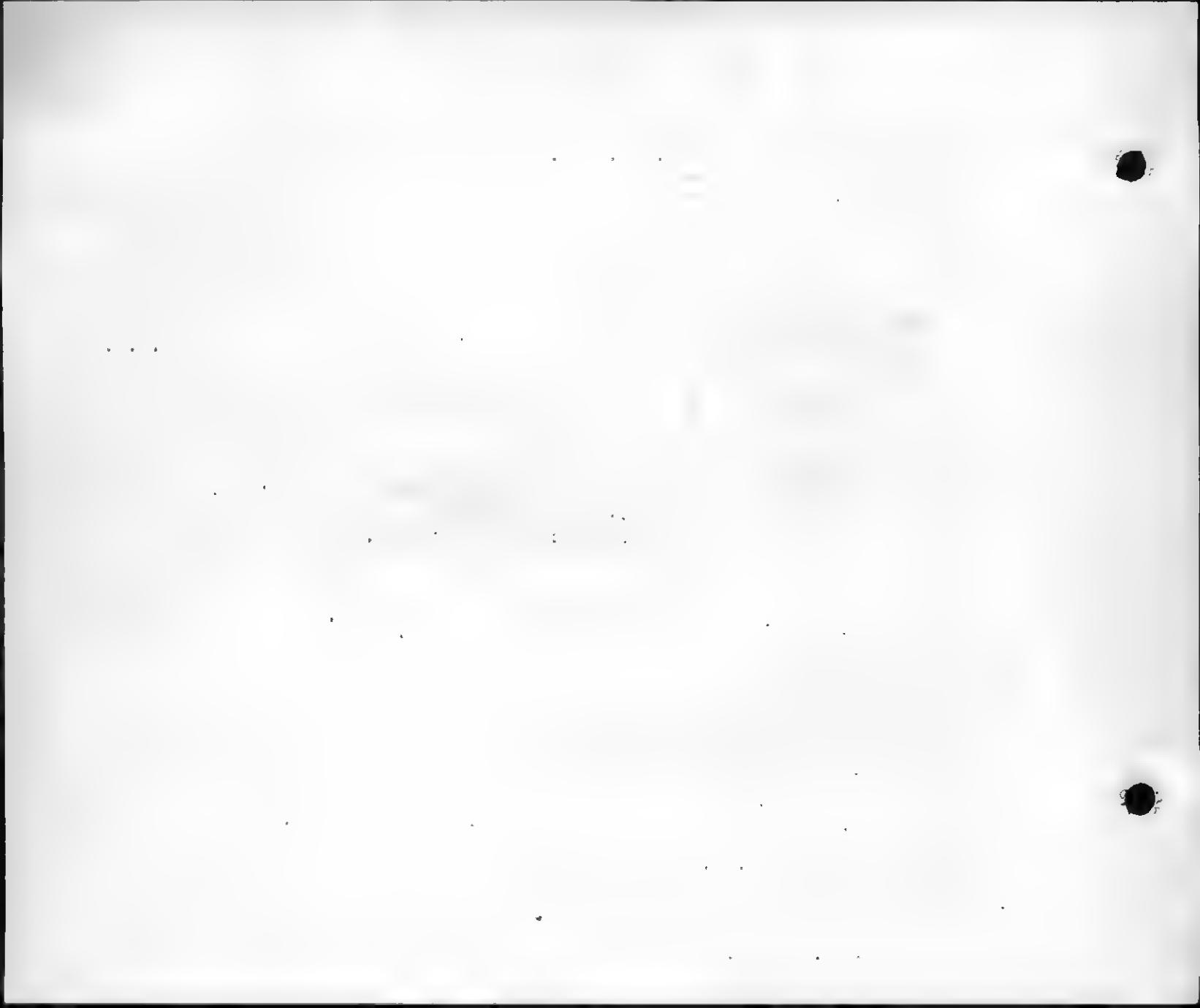
0488 CERTIFICATE OF DEATH

Reg. Dist. No. *00482*

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 6yr. 5mo. 11da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 3004 Cresmont Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Stella	Middle Bowne	Last Sprague	4. DATE OF DEATH January	Month January	Day 8	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-28-72	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 87 yrs.	IF UNDER 24 HRS. Hours 87 yrs.	IF UNDER 24 HRS. Min 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steven Sprague		14. MOTHER'S MAIDEN NAME Sara Sprague					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis with acute heart failure							
420.0 DUE TO and terminal pneumonia;							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease.							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-24 , 19 53 , to 1-8 , 19 60 , that I last saw the deceased alive on 1-8 , 19 60 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED 1-8-60							
ACTUAL SIGNATURE <i>Ilse Kamm</i>							
M.D. Springfield State Hospital							
PHYSICIAN'S NAME (Type) Ilse Kamm, M. D.							
Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1-11-60		22c. NAME OF CEMETERY OR CREMATORIUM Green Mount		22d. LOCATION (City, town, or county) Baltimore (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook, Inc., 1217 St. Paul Street							
24a. REC'D BY REGISTRAR DATE JAN 12 '60				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kamm</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

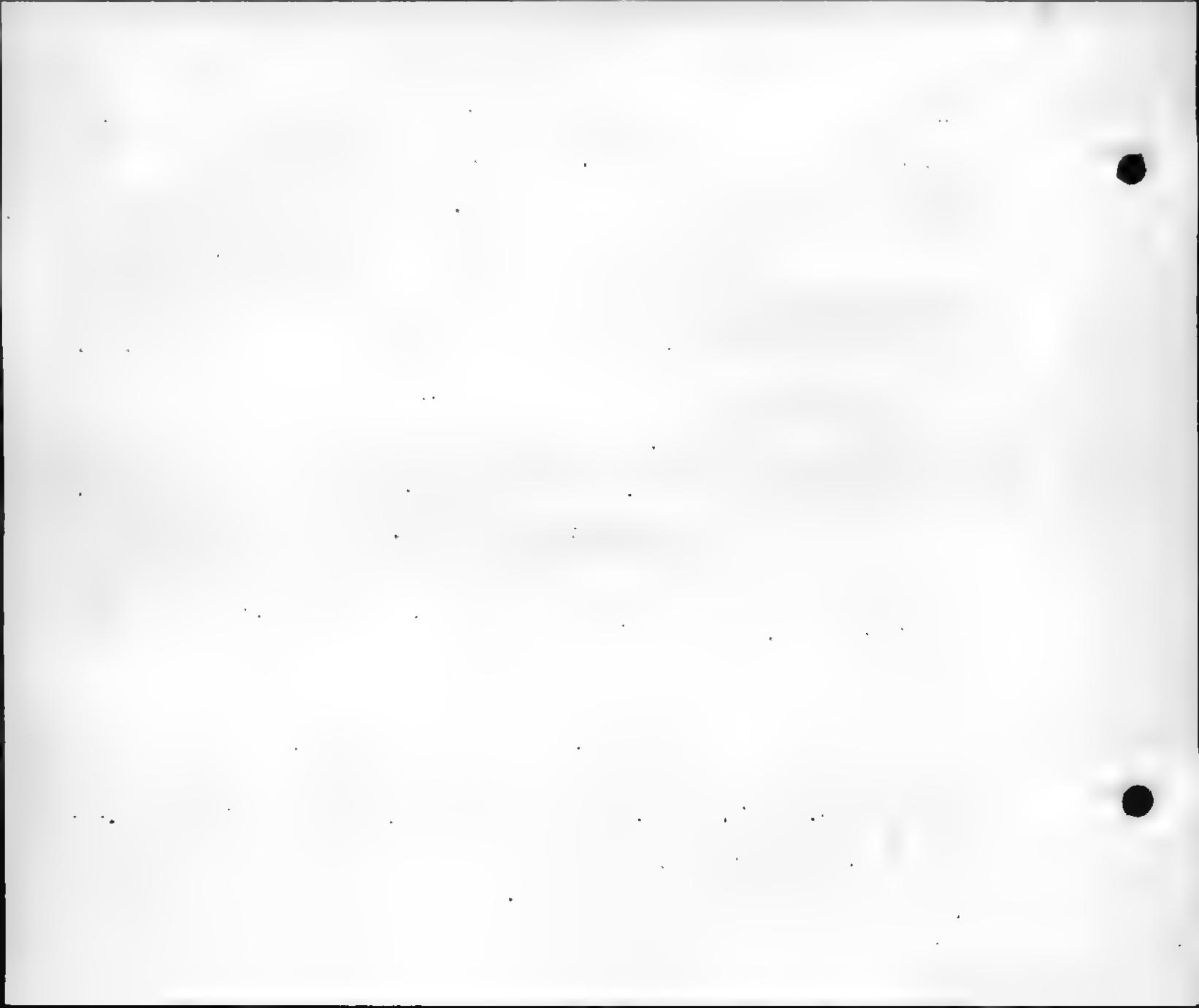
CERTIFICATE OF DEATH

Reg. Dist. No.

00483

0484

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5y. 11 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ANNIE	Middle E.	Last HAHN
4. DATE OF DEATH	Month January	Day 5	Year 19 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-1875
9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David Marshall	14. MOTHER'S MAIDEN NAME Caroline Seacrist		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No	16. SOCIAL SECURITY NO. Unk.	INFORMANT Records, Springfield State Hospital	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease			
INTERVAL BETWEEN ONSET AND DEATH Years.			
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Generalized arteriosclerosis. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with senile brain disease, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1955 , to January 5, 1960 , that I last saw the deceased alive on January 5, 1960 , and that death occurred at 6:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustín del Campo</i>		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustín del Campo, M. D.		DATE SIGNED 1-5-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Barrel	22b. DATE THEREOF 1-8-1960	22c. NAME OF CEMETERY OR CREMATORIUM Evergreen Cemetery	22d. LOCATION (City, town, or county) Gettysburg
23. FUNERAL DIRECTOR'S SIGNATURE Donald Petros 921 Carlisle St		ADDRESS Gettysburg Pa	24a. REC'D BY REGISTRAR DATE JAN 8 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Thomas



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

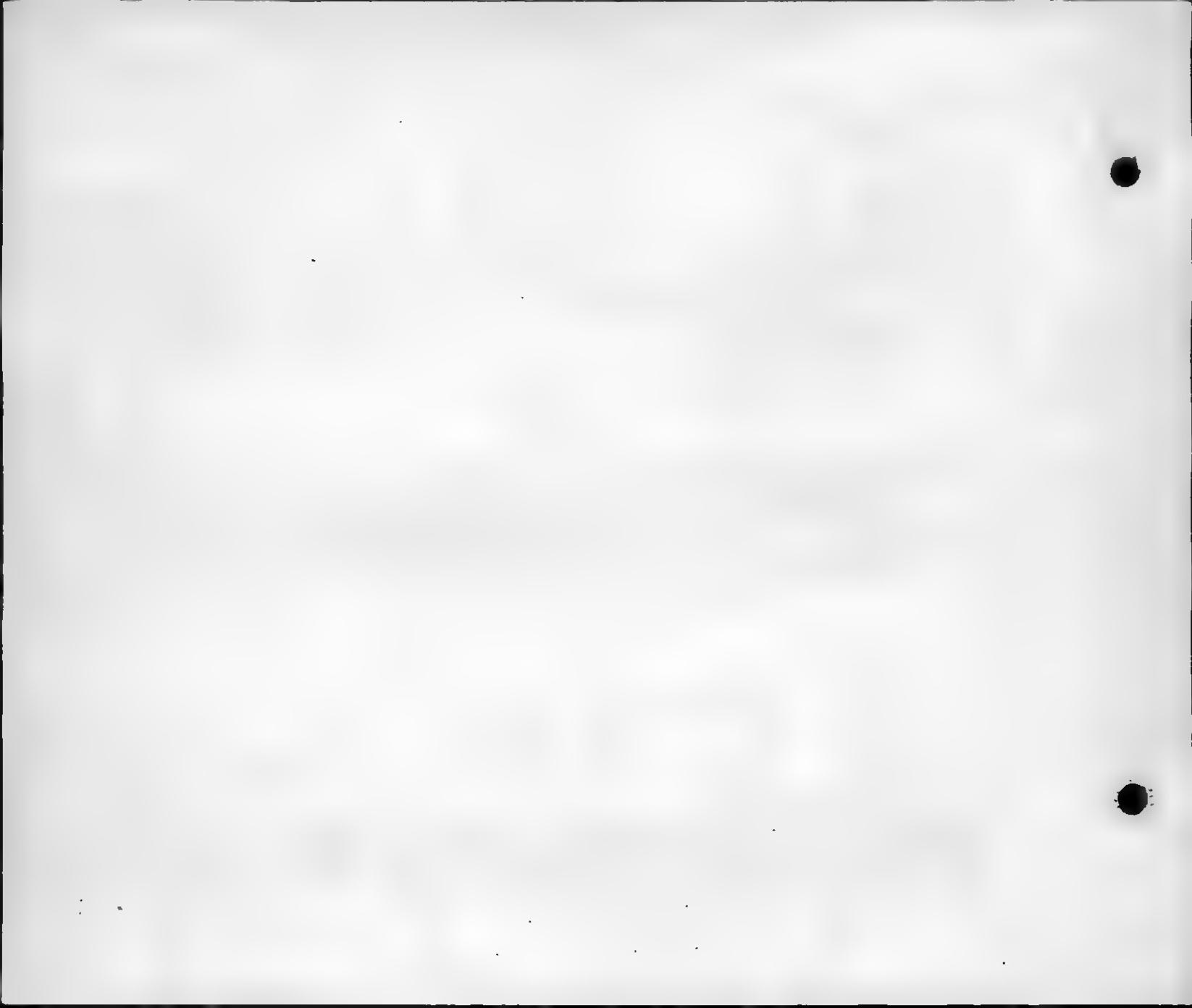
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00484

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		0490		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester - Rural</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester - Rural</u>		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>ROBERT - LAKER - HALE</u>		First	Middle	Lost	4. DATE OF DEATH <u>Feb 15-1922</u>	Month	Day	Year
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15-1922</u>	9. AGE (in years from birthday) <u>37</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>	12. IF UNDER 24 MRS Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>71st</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Hale</u>		14. MOTHER'S MAIDEN NAME <u>Hilda Lauer</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W-1-72-220-40-5430</u>		17. INFORMANT <u>Hora Schaeffer-Hale</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO <u>Asphyxia</u>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	DUE TO <u>House trailer fire</u>					
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>House trailer burned</u>						
20c. TIME OF INJURY Hour <u>4</u> p.m.		20d. INJURY OCCURRED At work <input type="checkbox"/> Of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Manchester Center Md</u>	(County) <u>Montgomery Co</u>	(State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>James T. March</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) <u>JAMES T. MARCH</u>		DATE SIGNED <u>1/22/60</u>						
22a. BURIAL, CREMATION, REMOVAL (Spec) <u>Burial</u>		22b. DATE THEREOF <u>1-26-1960</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Bethel National Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore Md</u>	(State) <u>Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eden & Tipton - Hampstead Md</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>DATE JAN 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Hauer</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0491 CERTIFICATE OF DEATH

Reg. Dist. No. 00485

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Baltimore City 311	
c. LENGTH OF STAY IN lb 35 yrs 7 mths 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital.		d. STREET ADDRESS 2814 Waterview Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Annie	Middle	Last Herion
4. DATE OF DEATH	Month 1	Day 3	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 76	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months 7 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown	16. SOCIAL SECURITY NO. —	INFORMANT Hospital records	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease.			
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Generalized arteriosclerosis years			
DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Involutional Psychotic Reaction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) — (County) — (State) —	
21. I certify that I attended the deceased from 3-7- , 19 55 , to 1-3- , 19 60 , that I last saw the deceased alive on 1-3- , 19 60 , and that death occurred at 3.30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 1-3-1960	
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-6-60	22c. NAME OF CEMETERY OR CREMATORIUM LOUDON PARK	22d. LOCATION (City, town, or county) BALTO MD (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul E. Johnson Jr.</i>		ADDRESS 367 Chestnut Ave	24a. REC'D BY REGISTRAR JAN 4 '60
			24b. REGISTRAR'S SIGNATURE Charles E. Tracy

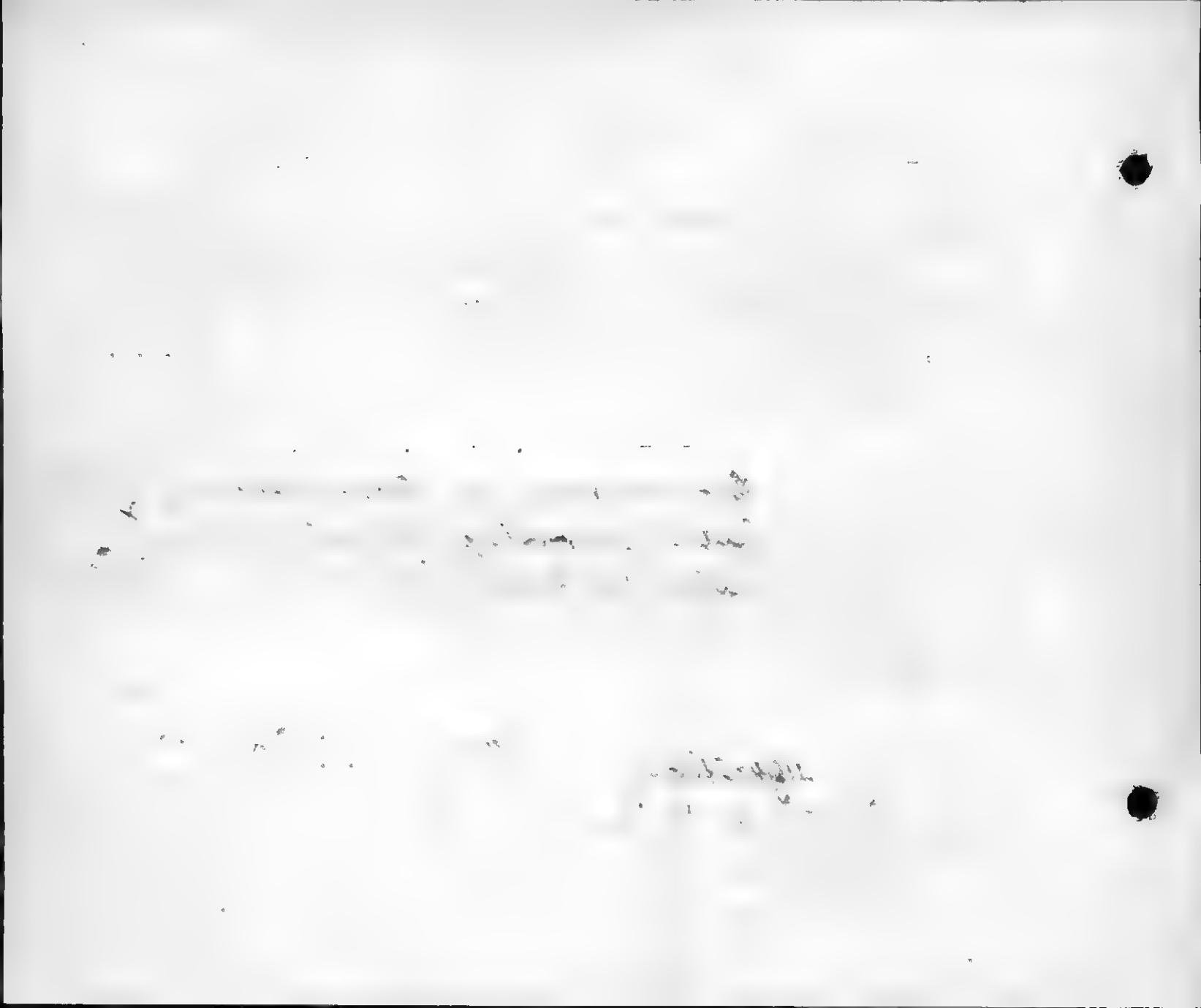


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0492 CERTIFICATE OF DEATH

00486

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Westminster		b. COUNTY Carroll					
c. LENGTH OF STAY IN 1b 19 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural --- Westminster					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at Winfield		d. STREET ADDRESS at Winfield					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ARTHUR		First D.	Middle KEEFER				
4. DATE OF DEATH January 27 1960		Month	Day Year				
S SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-1885				
9. AGE (in years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, -- retired		10b. KIND OF BUSINESS OR INDUSTRY Owner					
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frank Keefer		14. MOTHER'S MAIDEN NAME Lydia Shriner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 289-20-4130					
17. INFORMANT Mrs. Ruth A. Keefer, Same		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH Bronchial pneumonia, Cardiac failure. Jan 60 Central nervous system, rt side hemiplegia Jan 60 Cerebrovascular accident 27 Jan 60					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 16 to 27 Jan 1960, that (I) (we) last saw the deceased alive on 27 Jan 1960, and that death occurred at 8:00 from the causes and on the date stated above.		22a. SIGNATURE Howard E. Hall		22b. DATE 1-27-60			
22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS SYKESVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-30-1960		23c. NAME OF CEMETERY OR CREMATORIAL Ebenezer Cemetery		23d. LOCATION (City, town, or county) (State) Carroll, Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Wallz		ADDRESS Winfield, Maryland		25a. REC'D BY REGISTRAR DATE JAN 29 '60		25b. REGISTRAR'S SIGNATURE C. M. Wallz	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0460 CERTIFICATE OF DEATH

Reg. Dist. No. 00487

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Pennsylvania</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marysville</i>		c. LENGTH OF STAY IN 1b <i>4 Days.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover.</i>				
3. NAME OF DECEASED (Type or print) <i>Jacob</i>		First <i>J</i>	Middle <i>Kettnerman</i>			
3. NAME OF DECEASED (Type or print) <i>Jacob</i>		Last <i>Kettnerman</i>	4. DATE OF DEATH <i>January 20 1960</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>Sept 26 1883</i>		9. AGE (In years lost birthday) <i>76 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Meat Market</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George Kettnerman</i>				
14. MOTHER'S M AIDEN NAME <i>Susan Shue.</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16. SOCIAL SECURITY NO. <i>188-14-2466</i>		17. INFORMANT <i>Mrs Ella Kettnerman Hanover Pa.</i>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis.</i>		INTERVAL BETWEEN ONSET AND DEATH				
4.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) — (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteria. Sclerotic Corde. Cardi. Disease</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Hour o. m. <i>—</i> p. m. <i>—</i>	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from <i>JAN 17, 1960</i> to <i>JAN 20, 1960</i> that I last saw the deceased alive on <i>January 19, 1960</i> , and that death occurred at <i>4:45 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Hanover, Pa.</i>		DATE SIGNED <i>1/20/60</i>		
ACTUAL SIGNATURE <i>Joseph E. Bush</i>		M.D.				
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush</i>		ADDRESS <i>170 HAMPSTEAD MD.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/23/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>MT OLIVET</i>	22d. LOCATION (City, town, or county) <i>Hanover, York Co. Pa.</i>	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr. Westminster, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR <i>Arthur S. Thorne</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>		
VS A15 (4) 15M 9/55		DATE <i>JAN 25 '60</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0493 CERTIFICATE OF DEATH

Reg. Dist. No.

00488

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		M	
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balt. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 9yrs. 8mos. 8days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. STREET ADDRESS 2524 Park Heights Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sophia Middle Laff		4. DATE OF DEATH Month January Day 11, Year 1960	
5. SEX Female White		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH November 7, 1908	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) 51 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Unknown ✓	
13. FATHER'S NAME Ydah Laff		14. MOTHER'S MAIDEN NAME Bessie Cowan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right ventricular hypertrophy 002X DUE TO		Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculous fibrosis DUE TO		Years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenia, hebephrenic type.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955, to January 11, 1960, that I last saw the deceased alive on January 11, 1960, and that death occurred at 12:10 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Agustin del Campo M.D.		Springfield State Hospital 1/11/60	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 13-1960	
22c. NAME OF CEMETERY OR CREMATORIY Rosedale		22d. LOCATION (City, town, or county) Balt. City	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Jr. - 2100 Eutaw Place		24a. REC'D BY REGISTRAR DATE JAN 13 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0481 CERTIFICATE OF DEATH

00481

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 mo. 24 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE MARYLAND		e. COUNTY Maryland		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First John	Middle Ernest	Last LaMotte	4. DATE OF DEATH January	Month 29	Day 1960						
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-1888		9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Lewis Edward LaMotte		14. MOTHER'S MAIDEN NAME Lula E. Myerly										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 44-78-9715		17. INFORMANT Springfield Hospital Records		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Arteriosclerotic heart disease PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS, associated with chronic alcoholism plus cerebral arteriosclerosis hemiplegia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
INTERVAL BETWEEN ONSET AND DEATH years												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from 8-5-59 to 1-29 , 1960, that (I) (we) last saw the deceased alive on 1-29 , 1960, and that death occurred at 2:00 P.M. from the causes and on the date stated above.												
22a. SIGNATURE Edmund Lusthaus		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-29-60				
22c. PHYSICIAN'S NAME (Type) Dr. Edmund Lusthaus		22d. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-2-60		23c. NAME OF CEMETERY OR CREMATORIAL Secoy Methodist Cemetery		23d. LOCATION (City, town, or county) Otterbein 60 1/2 Rd		(State)				
24. FUNERAL DIRECTOR'S SIGNATURE Ball & Yipson		ADDRESS Hampstead Tild		25a. REC'D BY REGISTRAR FEB 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0401 CERTIFICATE OF DEATH

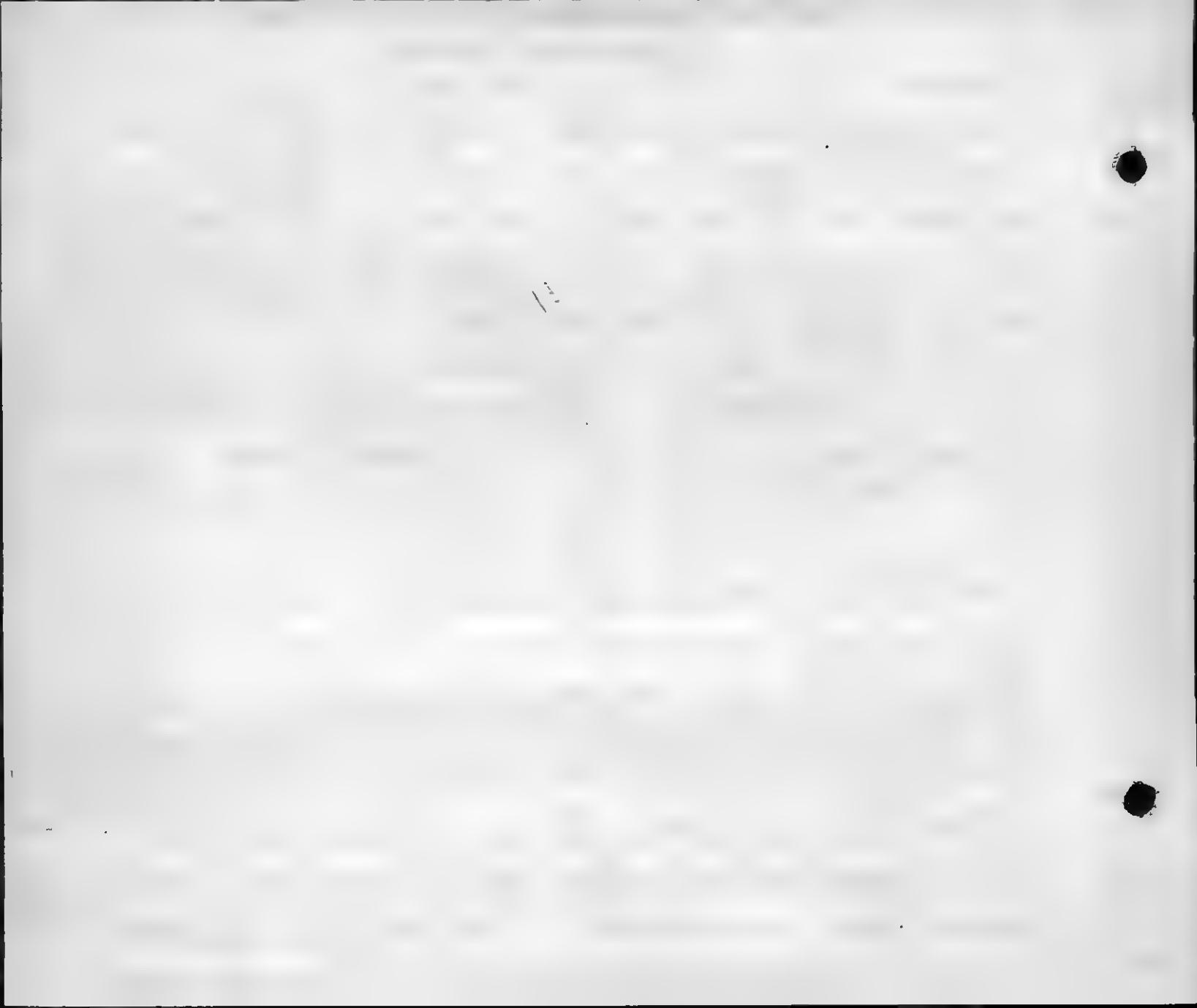
Reg. Dist. No. 100490

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>		b. COUNTY <i>Carroll</i>	
c. LENGTH OF STAY IN 1b <i>2 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Public Health Clinic</i>		d. STREET ADDRESS <i>13 York St</i>	
3. NAME OF DECEASED (Type or print) <i>Elmer E. Lippy</i>		First <i>E</i>	Middle <i>l</i>
4. DATE OF DEATH <i>1/23/60</i>		Month <i>Jan</i>	Day <i>2</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>Wh</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>1/23/1877</i>		9. AGE (In years last birthday) <i>82</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painting</i>	10c. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md</i>
11. MOTHER'S NAME <i>Elvira B. Lippy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John B. Lippy</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth M. Thruett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>44-313-0000</i>	
17. INFORMANT <i>Brodrich Lippy Manchester, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest, Arterosclerotic heart disease</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>		(b) <i>Hypertension, at time of origin - bronchial</i>	
DUE TO <i> </i>		(c) <i>Pneumonia.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>6-20-59 70 2 Jan 60</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-20</i> , 19 <i>60</i> , to <i>2-1</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2-1</i> , 19 <i>60</i> , and that death occurred at <i>10:05 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i>		ADDRESS (Street, city or town, state) <i>Sparks, Md</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>2 Jan 60</i>	
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/25/60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Manchester Cemetery</i>		22d. LOCATION (City, town, or County) <i>Manchester, Md Carroll Co.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Buckley Funeral Par</i>		24a. ADDRESS <i>1515 E. 36th St., Baltimore, Md</i>	
24b. REC'D BY REGISTRAR <i>C. Thompson</i>		24c. DATE JAN 5 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0498 CERTIFICATE OF DEATH

Reg. Dist. No. 06491

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal, Westminster, Md.</u>		c. LENGTH OF STAY IN 1b <u>all her life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>near Carrollton</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal, Westminster</u>	
3. NAME OF DECEASED (Type or print) <u>ANNIE REBECCA LONG</u>		First <u>A</u>	Middle <u>R</u>
4. DATE OF DEATH <u>JAN. 25 1960</u>		Month <u>JAN.</u>	Day <u>25</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1879</u>
		WIDOWED <input type="checkbox"/>	9. AGE (In years lost birthday) <u>80 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Elias Hock</u>		14. MOTHER'S MAIDEN NAME <u>Martia Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Mary J. Long</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <u>Cerebral hemorrhage & days afteriosclerosis 25 + with my dementia of yrs</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>—</u>		DUE TO <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>	
		(b) <u>—</u>	
		DUE TO <u>—</u>	
		(c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Jan 25, 1960</u> to <u>Jan 25 1960</u> that I last saw the deceased alive on <u>Jan 25, 1960</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Reese Wilkens</u>		ADDRESS (Street, city or town, state) <u>15 Kemper Ave, Westminster, Md.</u>	
PHYSICIAN'S NAME (Type) <u>E. Reese Wilkens</u>		DATE SIGNED <u>1/26/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 28, 60</u>	
22c. NAME OF CEMETERY OR CEMETORY <u>Carrollton Church of God</u>		22d. LOCATION (City, town, or county) <u>Carrollton Carroll Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Major Jr., Westminster, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>John Major Jr., Westminster, Md.</u>	
DATE <u>Jan 28, 60</u>		DATE <u>Jan 28, 60</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

049 CERTIFICATE OF DEATH

Reg. Dist. No. 00492

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institut on Residence before admission] a. STATE Maryland		b. COUNTY Balto. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 47y.7m.3d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JOSEPH	Middle	Last LORDO	4. DATE OF DEATH January 5	Month	Day 19	Year 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1885	9. AGE (In years last birthday) 74? yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy		
13. FATHER'S NAME James Lordo				14. MOTHER'S MAIDEN NAME Unk.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.		INFORMANT Records, Springfield State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Nephrosclerosis Years Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO General arteriosclerosis Years (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Schizophrenic reaction, other and unspecified.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>March 7</u> , 1955, to <u>January 5</u> 1960, that I last saw the deceased alive on <u>January 5</u> , 1960, and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Agustini del Campo</u> M.D. <u>Springfield State Hospital</u> <u>1-5-60</u> PHYSICIAN'S NAME (Type) <u>Agustini del Campo, M.D.</u> Sykesville, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-60		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS Sykesville, Md.		24a. REG'D BY REGISTRAR JAN 11 1960		24b. REGISTRAR'S SIGNATURE Arthur H. Haight		
				DATE				

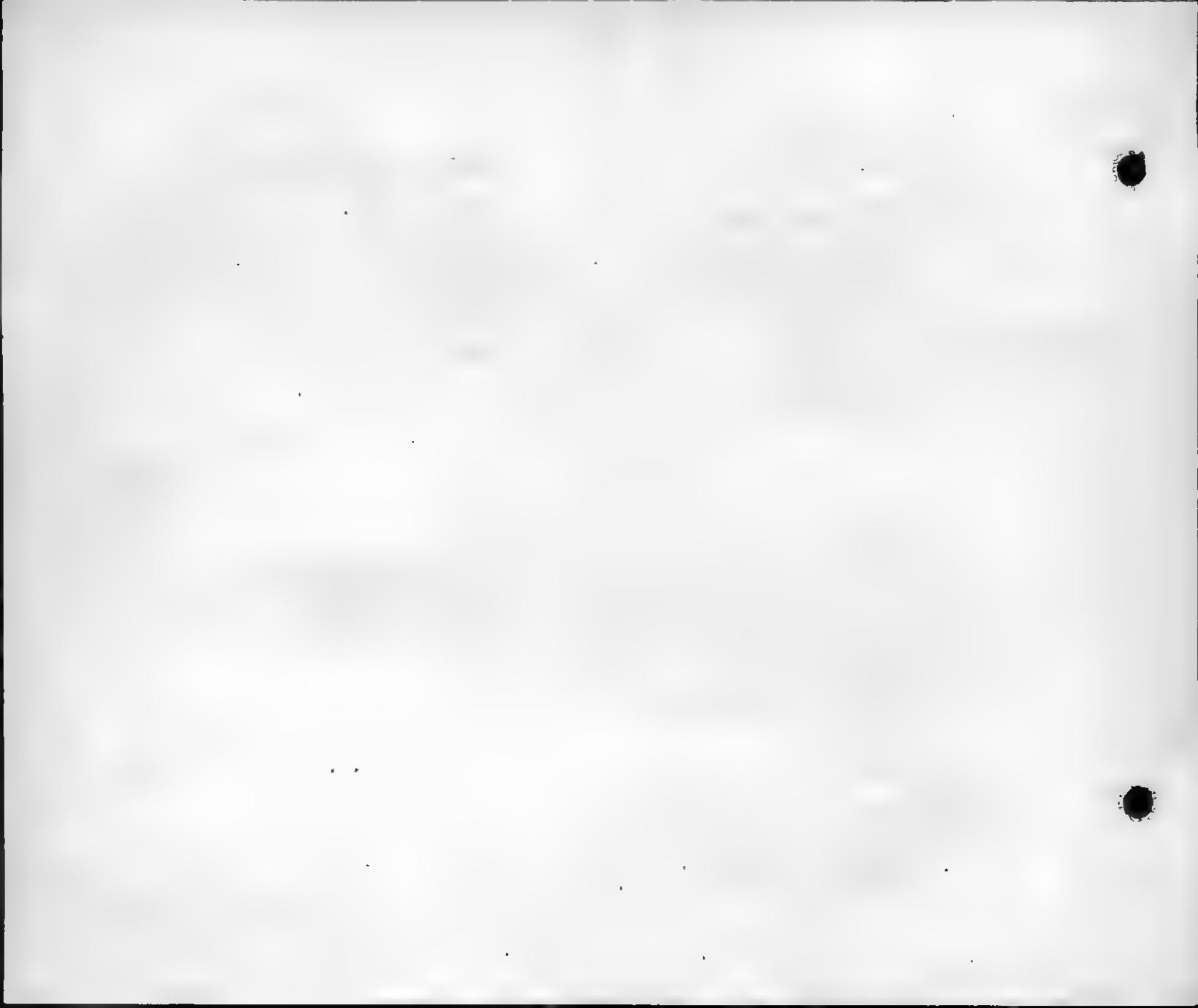


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
0498 CERTIFICATE OF DEATH

00498

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 9 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, #18 Maryland		d. STREET ADDRESS 2720 Hugo Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jeanette		First Jeanette	Middle L.	Last Macaulay	4. DATE OF DEATH 1	Month 11	Day 1960
5. SEX female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/17/1888	9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARION LINDSAY				14. MOTHER'S MAIDEN NAME LAURA J. LEVERTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1 Acute myocardial insufficiency INTERVAL BETWEEN ONSET AND DEATH hours DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) Acute myocardial infarction hours DUE TO } (c) Arteriosclerotic cardio-vascular disease years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/11/60 19 to 1/11/60 19, that (I) (we) last saw the deceased alive on 1/11/60 19, and that death occurred at 8:55 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Agustini del Campo		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/11/60			
22c. PHYSICIAN'S NAME (Type) Agustini del Campo, M.D.		22d. ADDRESS Sykesville, Maryland					
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/14/60		23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK CEMETERY		23d. LOCATION (City, town or county) BALTIMORE MARYLAND (State)	
24. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS INC. BALTIMORE MD.				ADDRESS		25a. REC'D BY REGISTRAR DALE 14 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

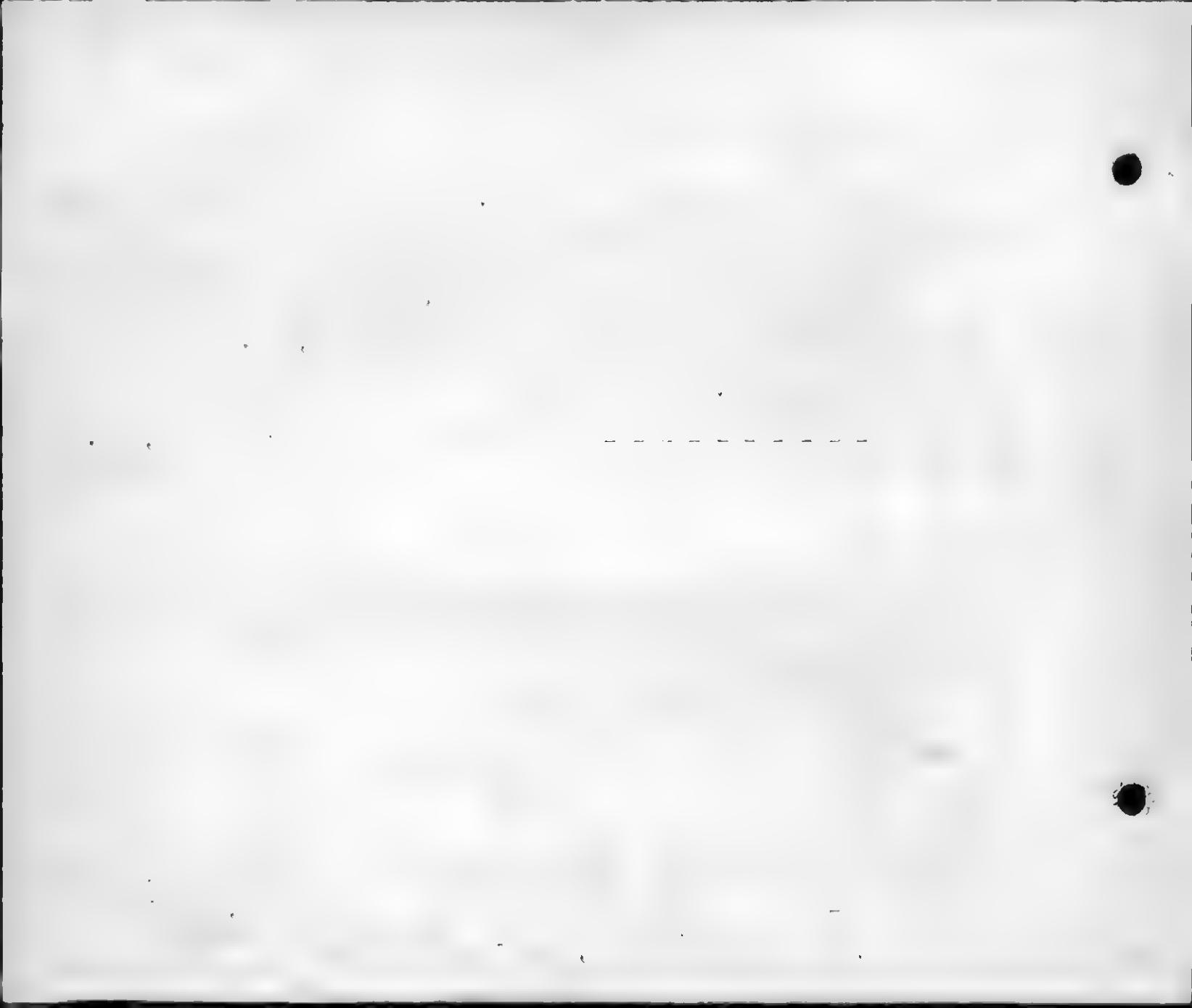
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 515-225 2-1-60 at
 U499 CERTIFICATE OF DEATH

00494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Mills		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadow View Convalescent Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster	
3. NAME OF DECEASED (Type or print) ELLA BLANCHE MAGEE		4. DATE OF DEATH Month JANUARY Day 26 Year 1960	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1869	
9. AGE (in years last birthday) 90 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Brown		14. MOTHER'S MAIDEN NAME Catherine Tawney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Address John L. Magee R 4 Westminster, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA INTERVAL BETWEEN ONSET AND DEATH 2 DAYS			
4/22/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) CONGESTIVE HEART FAILURE 1 MONTH	
DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
p. m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) -----		(County) ----- (State) -----	
21. I certify that I attended the deceased from JULY , 1959, to JANUARY 26 , 1960, that I last saw the deceased alive on JANUARY 25 , 1960, and that death occurred at 9:35 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) -----			
ACTUAL SIGNATURE William Lewis Stewart, M.D. DATE SIGNED 1/26/60			
PHYSICIAN'S NAME (Type) William Lewis Stewart WESTMINSTER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-60	
22c. NAME OF CEMETERY OR CREMATORIAL Sandymount Cemetery		22d. LOCATION (City, town, or county) Sandymount, Maryland (State) -----	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	
24a. REC'D BY REGISTRAR DATE JAN 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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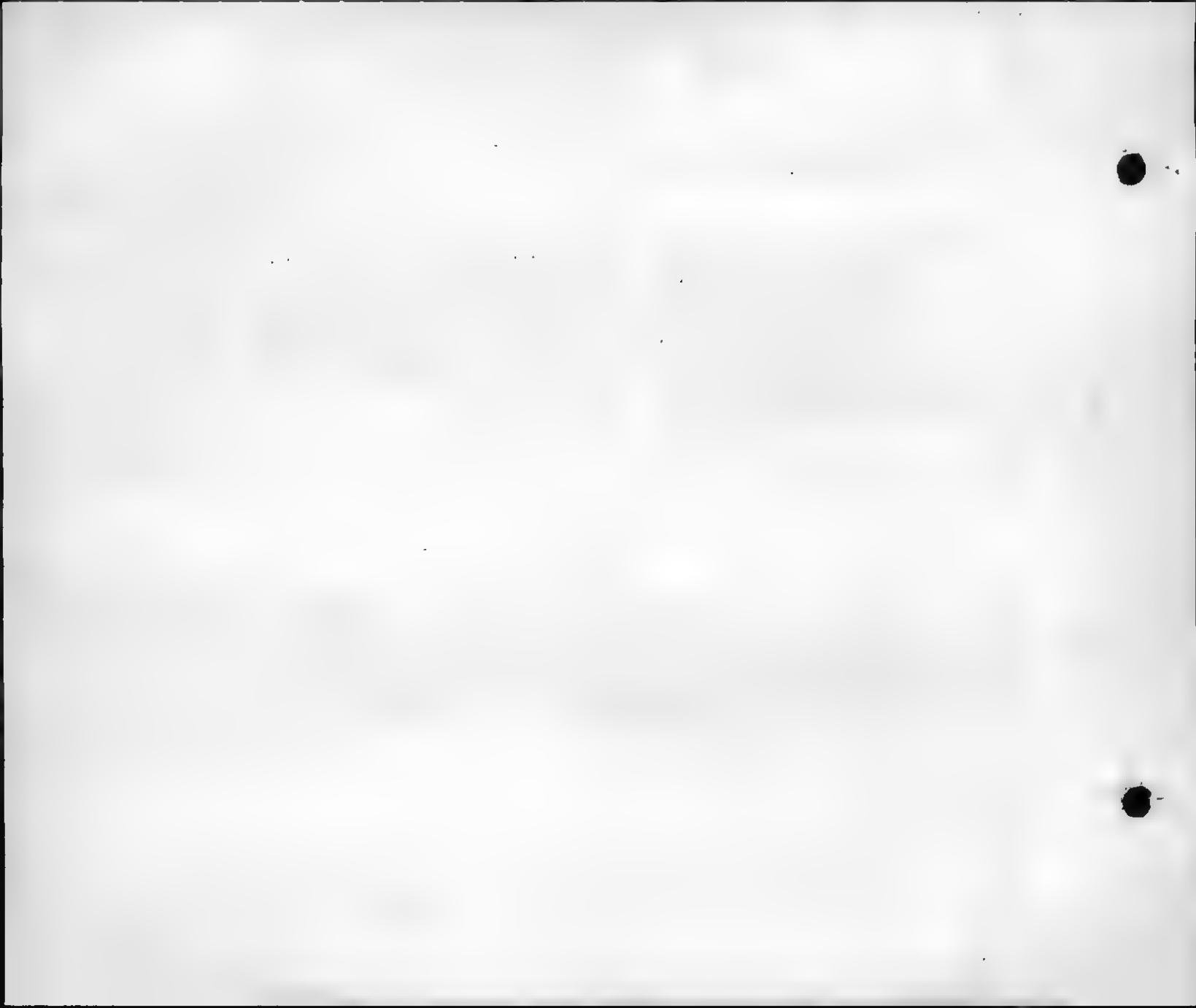
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0500

CERTIFICATE OF DEATH

00495

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Carroll</i> Rural, Sykesville		Md. Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 23 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS Freedom Road	
3. NAME OF DECEASED (Type or print)		First	Middle
CLAYTON		Thomas	MARRINER
4. DATE OF DEATH		Month	Day
Jan 26		Year	1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
m		w	Oct. 16, 1892
8. AGE (In years last birthday)		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days Hours Min.
67 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Carpenter		P. R. R.	Md.
12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Francis W. Mariner		Sarah F. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
(If yes, give war or dates of service)		717-07-6133	Mrs Rachel Mariner - Sykesville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Central hemorrhage, coronary thrombosis 1857	
DUE TO (b) DUE TO (c)		Cardiac failure, arteriosclerosis 70 generalized - 26 Jan 60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from... 1957 19 1a. 36 Jan 1960, that (I) (we) last saw the deceased alive on 26 Jan 1960 and that death occurred at 6507, from the causes and on the date stated above.		22b. DATE 5 QNED	
22a. SIGNATURE <i>Howard E. Hall</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	1-27-60
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Howard E. Hall 94 Kesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-29-60	23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Memorial Gardens
24. FUNERAL DIRECTOR'S SIGNATURE <i>Julie A. Haight</i>		ADDRESS Sykesville, Md.	23d. LOCATION (City, town, or county) Glenelg, Carroll, Md. (State)
			25a. REC'D BY REGISTRAR DATE FEB 2 '60
			25b. REG STRR'S SIGNATURE <i>Charles S. Turner</i>

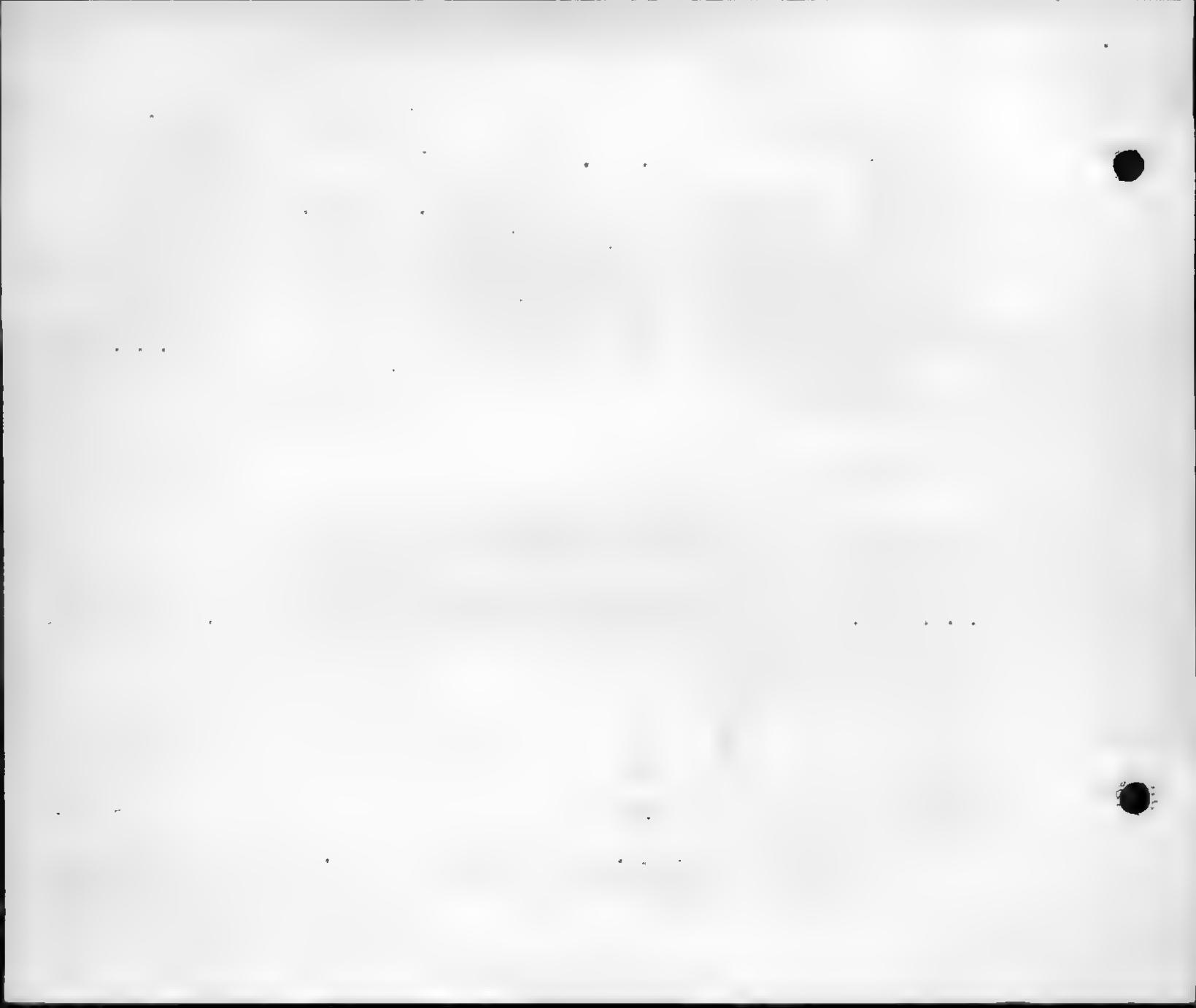


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00496

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3yrs. 5mos. 15days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Mary Pauline Jenkins		d. STREET ADDRESS 508 N. Eutaw St.	
4. DATE OF DEATH January 22, 1960		Month	Day
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 1, 1883	
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Maselkowski		14. MOTHER'S MAIDEN NAME Pauline Suwalski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral accident			
002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Pulmonary tuberculosis Years			
C. D. L. (c) DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from August 7, 1956 , to January 22, 1960 , that (H) (we) last saw the deceased alive on January 21, 1960 , and that death occurred at 1:10 AM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo.		22b. DATE SIGNED 1/22/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Sykesville, Md. - Springfield Hospital	
23a. BURIAL CREMATION OR REMOVAL (Specify) Burial Jan 25/60		23c. NAME OF CEMETERY OR CREMATORIAL Burial Pt.	
23d. LOCATION (City, town, or county) Baltimore		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Philip Harvey Fine Orlinmost.		25a. REC'D BY REGISTRAR DATE JAN 26 1960	
ADDRESS 2024		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

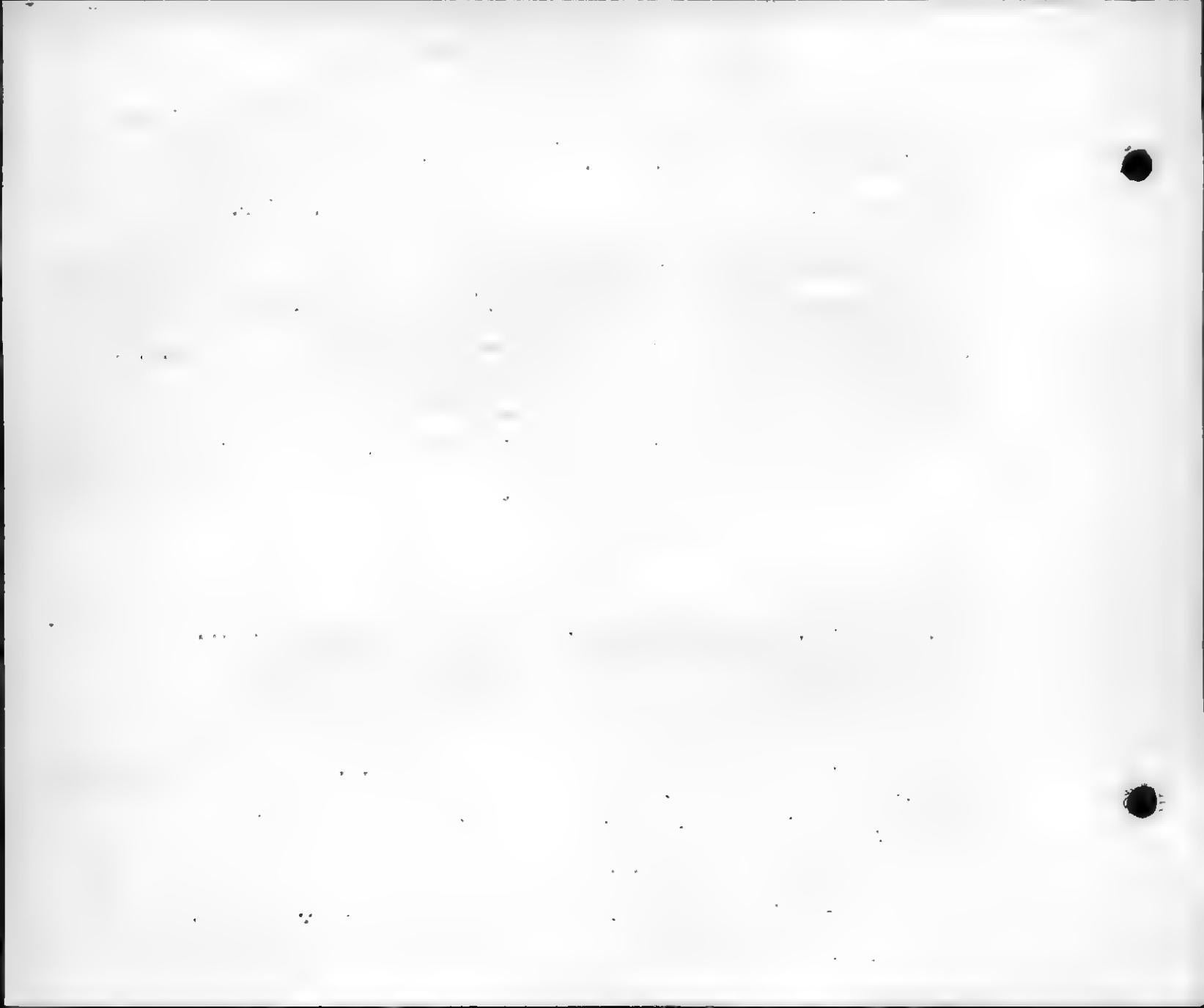
0502

CERTIFICATE OF DEATH

Reg. Dist. No.

00497

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11 days 1 yr. 4 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) ELIZABETH MARTON REPP		d. STREET ADDRESS 4500 Harford Rd. Balto. #14	
4. DATE OF DEATH Month Day Year 1 1 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Repp		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Bronchopneumonia left side		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) DUE TO Cardiac failure		2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) —	
20c. TIME OF INJURY Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/30/59 , 19, to 1/1/60 , 19, that I last saw the deceased alive on 1/1/60 , 19, and that death occurred at 11:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Agustin del Campo M.D. Sykesville, Maryland		DATE SIGNED 1/1/60	
ACTUAL SIGNATURE Agustin del Campo		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-4-60	
22c. NAME OF CEMETERY OR CREMATORIAL Swartz Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd		24a. REC'D BY REGISTRAR DATE JAN 4 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

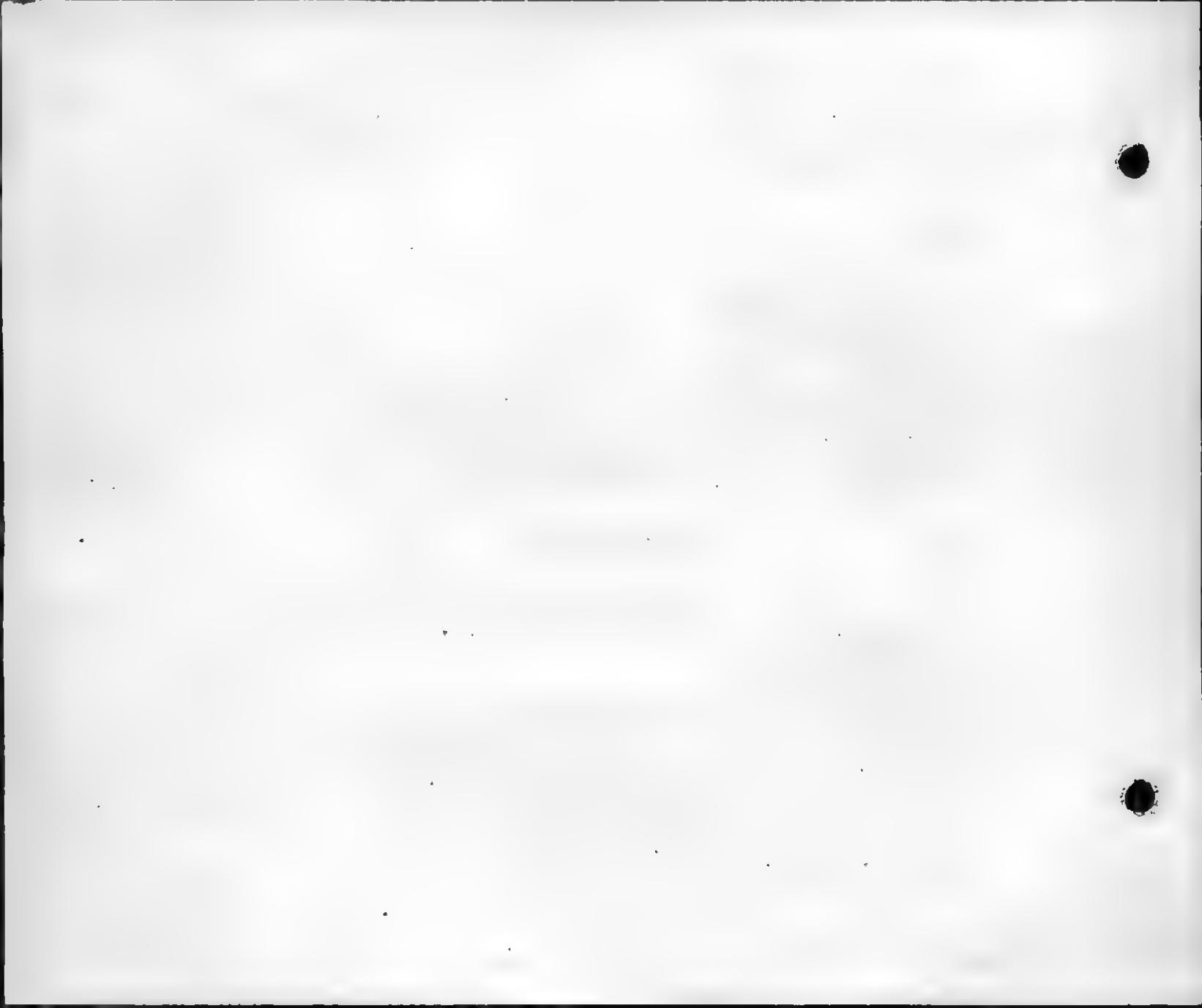


1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00498

X CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		0503		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>		c. LENGTH OF STAY IN 1b <i>40 yrs</i>		b. COUNTY <i>Carroll</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>		d. STREET ADDRESS <i></i>						
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <i>GARRET - A - MILLER</i>		First	Middle	Last	4. DATE OF DEATH <i>Jan 29 1960</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 7-1886</i>	9. AGE (In years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>been farmed</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>						
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>										
13. FATHER'S NAME <i>William H Ruby</i>		14. MOTHER'S MAIDEN NAME <i>Hester Steansbury</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						
16. SOCIAL SECURITY NO <i>266-22-1743</i>		17. INFORMANT <i>Mrs W. H. Joiner - Hampstead Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>						
332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterio-Sclerosis				INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>						
(c)				5 yrs.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Repeated Thromboses for past three years.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Hampstead</i>	(County) <i>Maryland</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>1/25/60</i> , 19, to <i>1/29/60</i> , 19, that I last saw the deceased alive on <i>1/25</i> , 19, 60, and that death occurred on <i>11:45 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>M.C. Porterfield, M.D.</i>		ADDRESS (Street, city or town, state) <i>Hampstead Maryland</i>				DATE SIGNED <i>1/29/60</i>				
PHYSICIAN'S NAME (Type) <i>M.C. Porterfield, M.D.</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 1-1960</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Hampstead</i>		22d. LOCATION (City, town, or county) <i>Carroll Co. Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie D. Dipton - Hampstead Md</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>FEB 2 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00493

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		0501 Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Union Bridge Rural - 20 yrs		a. STATE Maryland b. COUNTY Carroll		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge Rural		f. STREET ADDRESS		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	
RAYMOND - L - MINICK					January 15 1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years 1st birthday) 62 yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
M	W		3-29-1897	62 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Laborer		General		Md		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY		
Julius Minick		Mary Blocker		U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> 16. SOCIAL SECURITY NO. 17. INFORMANT		Address				
(If yes, give rank or dates of service) 156.1		Mrs Raymond Minick - Union Bridge Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 4 months				
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Carcinoma - Liver				
DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)						
DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/1/57, 19, to 11/15/60, 19, that I last saw the deceased alive on 11/4/60, 19, and that death occurred at 8:40 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)				DATE SIGNED
ACTUAL SIGNATURE M.E. Robertson		M.D. New Windsor, Md. 11/15/60				
PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-1960		22c. NAME OF CEMETERY OR CREMATORIAL Pipe Creek Cem.		22d. LOCATION (City, town, or county) Carroll Co - Md (State)
23. FUNERAL DIRECTOR'S SIGNATURE Saw G. Hupton - Hampstead Md		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
						Arthur S. Krause
				DATE JAN 18 '60		



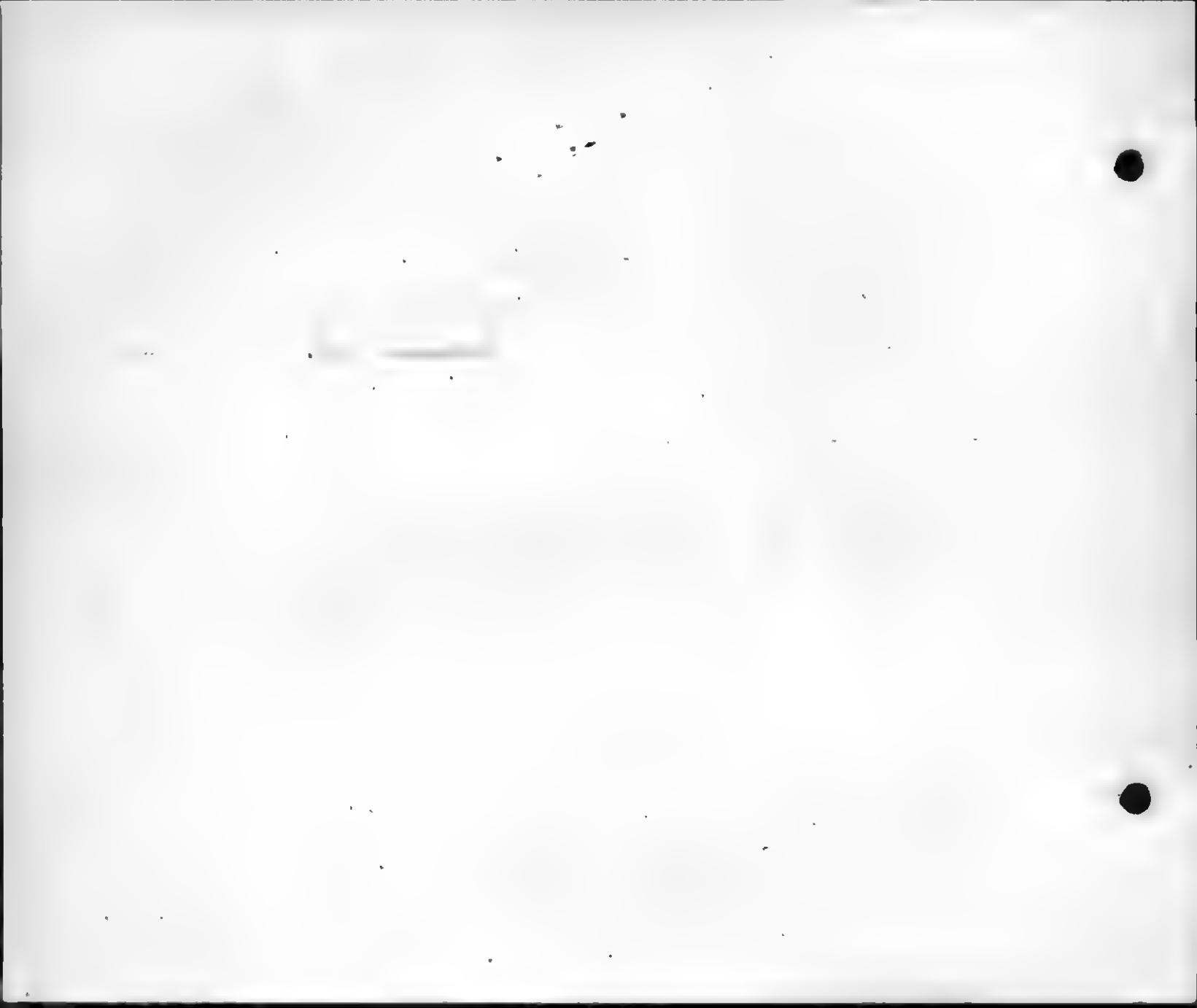
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 0505 CERTIFICATE OF DEATH 005.00

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Mt Airy</i>		c. LENGTH OF STAY IN 16 <i>1 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Watersville Road</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Delano Roosevelt Myers, Jr.</i>		First <i>Delano</i>	Middle <i>Roosevelt</i>
4. DATE OF DEATH <i>January 22 1960</i>		Last <i>Myers, Jr.</i>	Month Day Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>27 Aug 31 1859</i>		9. AGE (In years last birthday) <i>0 yrs.</i>	10. IF UNDER 1 YEAR Months <i>5</i> Days <i>19</i> Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painter</i>	11. BIRTHPLACE (State or foreign country) <i>Frederick, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Delano Roosevelt Myers</i>	
14. MOTHER'S MAIDEN NAME <i>Clara Bernice Jones</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>---</i>		INFORMANT <i>Mrs Clara Myers</i>	Address <i>Mt Airy</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Bronchial Pneumonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/21</i> , 19 <i>60</i> , to <i>1/22</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1/22</i> , 19 <i>60</i> , and that death occurred at <i>3:58 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.B. Culwell</i>		ADDRESS (Street, city or town, state) <i>900 So Main St</i>	
PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>		DATE SIGNED <i>1/22/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/24/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Simpson Chapel</i>
22d. LOCATION (City, town, or county) <i>Poplar Springs, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Alvin L. Mobsouth</i>		24a. REC'D BY REGISTRAR ADDRESS <i>Damascus, Md.</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
DATE JAN 26 '60			



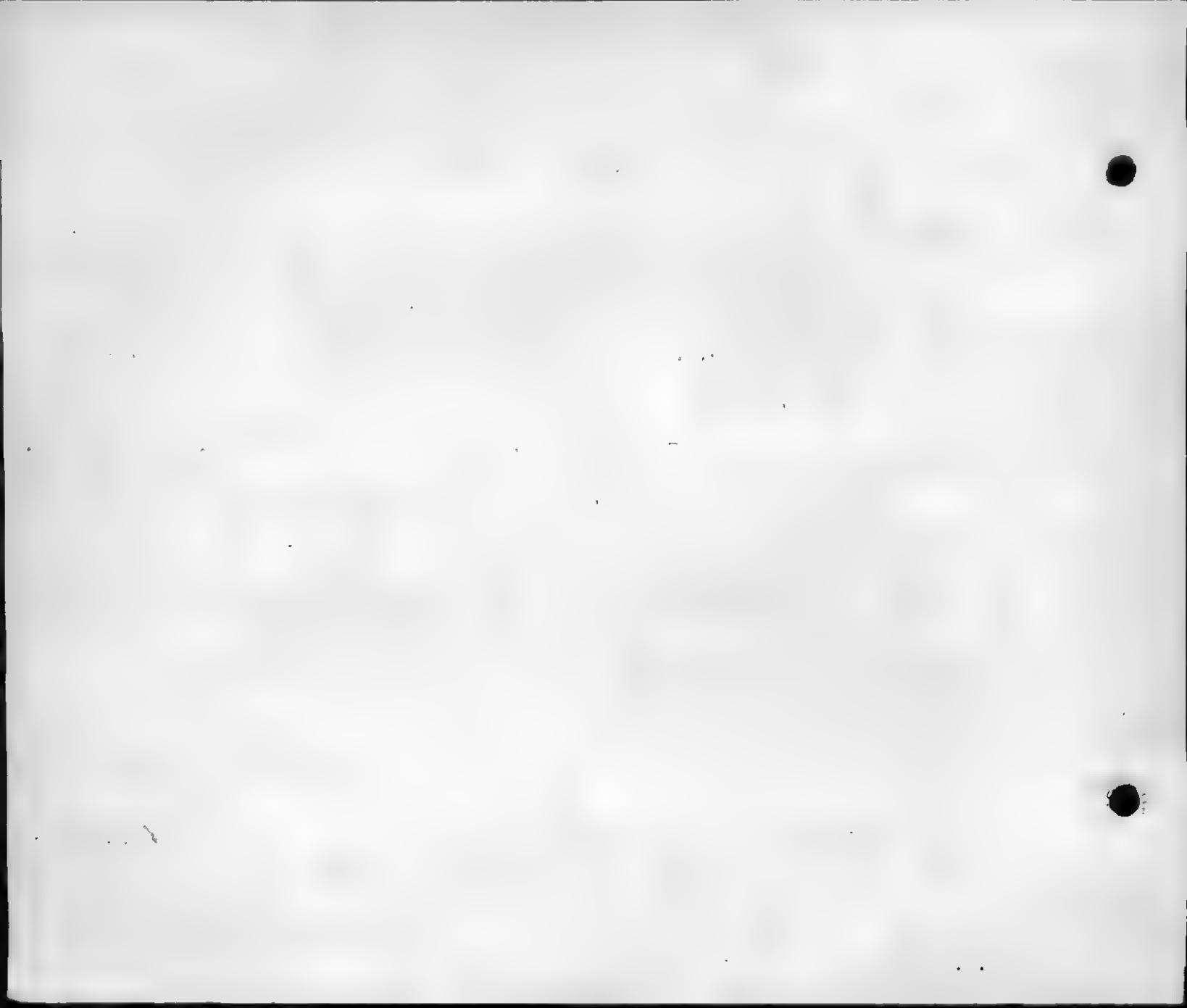
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11501

05/26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		X Rural Westminster	
e. STREET ADDRESS		f. IS RESIDENT ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Norman	Middle Theodore	Last Myers
4. DATE OF DEATH	Month January	Day 25	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1891
9. AGE IN YEARS 68 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Worker	10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Theodore J. Myers		
14. MOTHER'S MAIDEN NAME Mattie Koontz	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO 215-36-8328	17. INFORMANT Mrs. Norman T. Myers, Route #7, Westminster, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis 5 minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Hypertension & Coronary 2400 (c) Sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Wylem Specieker</i>	DATE SIGNED 1/25/60		
EXAMINER'S NAME (Type) Acting	D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 28, 1960	22c. NAME OF CEMETERY OR CEMATORIUM Kriders Cemetery	22d. LOCATION (City, town, or county) Westminster, Carroll Co., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Merle C. Fuss</i>	ADDRESS Co. Fuss & Son, Taneytown, Md.	24a. REC'D BY REGISTRAR DATE JAN 27 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by a hospital or attending physician and completely filled in by the medical director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00502

1. PLACE OF DEATH a. COUNTY		050 Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		Carroll		
Sylvanville		Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Sylvanville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
EARL		SYLVESTER		NORRIS	Jan, 23			1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
Male	Col.			Dec. 19 1903	56 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Laborer		Road Construction		Md.		U. S. A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
James D. Norris		Eliza Combash						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		220-03-2157		Mrs. Mabel Norris - Sylvanville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO <i>Cardiosclerosis, Coronary, heart -</i> 958								
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i>neuritis, bronchial pneumonia -</i> to 23 Jan 60								
DUE TO (c) <i></i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that (I) (this hospital) attended the deceased from 1958 19 to 23 Jan 19, that (I) (we) last saw the deceased alive on 23 Jan 1960, and that death occurred at 8P.M. from the causes and on the date stated above								
22a. SIGNATURE		M D		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED			
HOWARD E. HALL					1-25-60			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS				
HOWARD E. HALL				Sylvanville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county) (State)		
Burial		1-26-60		St. Luke's		Sylvanville Carroll, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Arthur H. Height		Sylvanville, Md.		FEB 2 '60		Arthur H. Height		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00503

1. PLACE OF DEATH a. COUNTY Carroll		0503 MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 38 yrs. 6 mos. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		38014		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 913 Arlington Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Annie		First A.	Middle Youse	Lost Peters	4. DATE OF DEATH January 15, 1960	Month January	Day 15	Year 1960
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1880		9. AGE (in years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William E. Youse			14. MOTHER'S MAIDEN NAME Margaret Lockland					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -		17. INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 002 X DUE TO Coronary occlusion								
Conditions, if any, which gave rise to immediate cause (a), striking the under- lying cause lost. (b) DUE TO Pulmonary tuberculosis								
(c) DUE TO Generalized arteriosclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Manic depressive reaction, manic type.								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 to January 15, 1960 , that (H) (we) last saw the deceased alive on January 15, 1960 , and that death occurred at 4:12 PM from the causes and on the date stated above								
22a. SIGNATURE <i>Agustin del Campo</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS.		22b. DATE SIGNED 1/15/60				
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/18/60		23c. NAME OF CEMETERY OR CREMATORIAL WOODLAWN		23d. LOCATION (City, town, or county) BALTIMORE, MD. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Denby, Jr.</i>		ADDRESS 715 L... - - -		25a. REC'D BY REGISTRAR JAN 18 1960		25b. REGISTRAR'S SIGNATURE <i>Charles S. Knapp</i>		



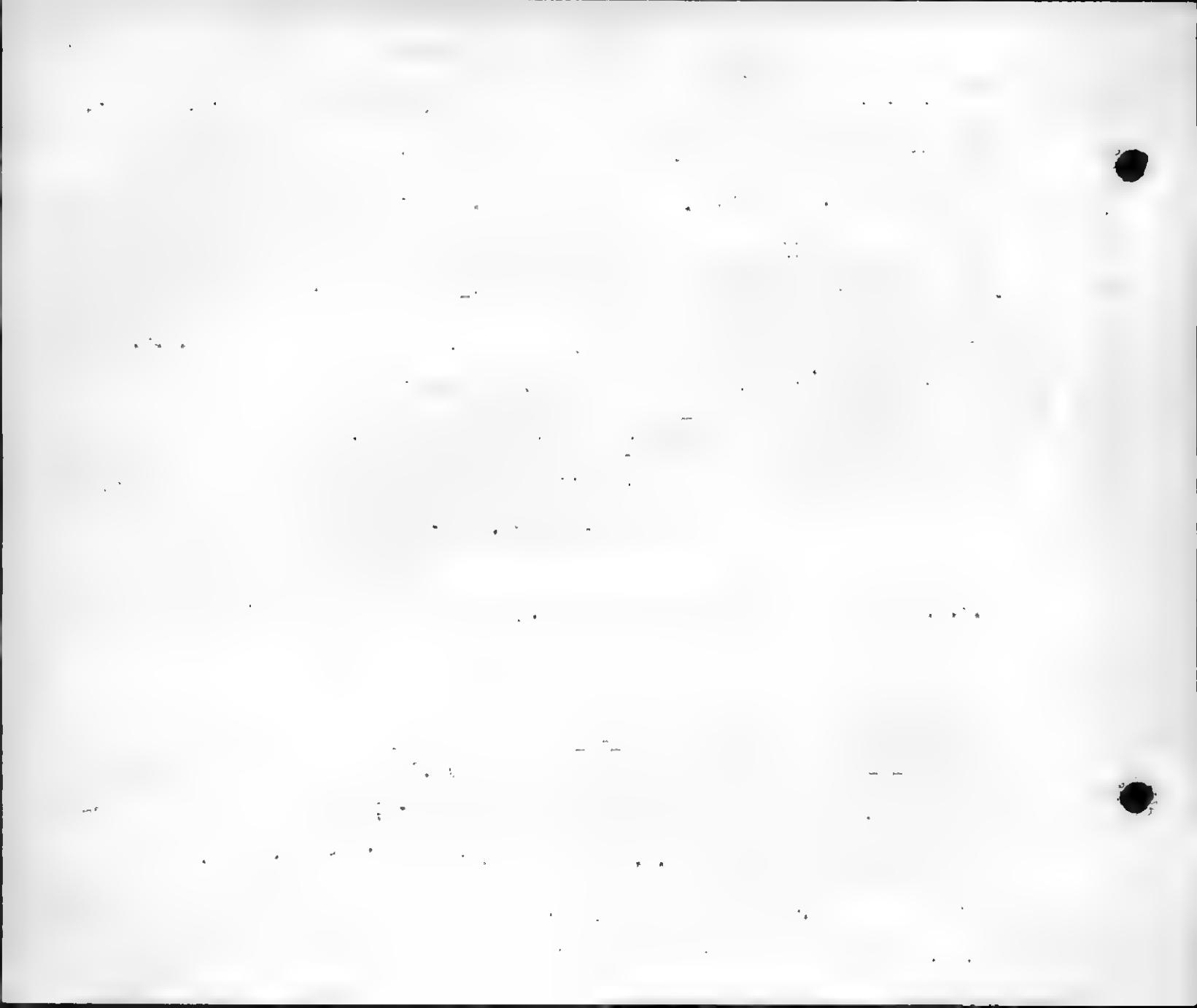
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00504

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick Co. 10	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		10 X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS Rt. 7 (Shookstown)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Albert	Middle Rudolph	Last Phelps	4. DATE OF DEATH 1	Month 1	Day 2	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-16-81	9. AGE (In years at birthday) 78 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rudolph Phelps		14. MOTHER'S MAIDEN NAME Louisa Boyce Carpenter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. INFORMANT Unk.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH years 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis years (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I (a) C.B.S. associated with senile brain disease, with psychotic reaction 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sykesville	(County)	(State) Maryland
21. I certify that I attended the deceased from 12-16-1959, to 1-2-1960, that I last saw the deceased alive on 1-2-1960, and that death occurred at 10.30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville Maryland DATE SIGNED 1-3-60							
ACTUAL SIGNATURE Agustin del Campo M.D.		PHYSICIAN'S NAME (Type) Agustin del Campo M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 5, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR JAN 5 '60	24b. REGISTRAR'S SIGNATURE C. J. S. Kraus		
VS A15 (4) 1SM 9/58		DATE					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,14 file G255 2-4-60 et

0510

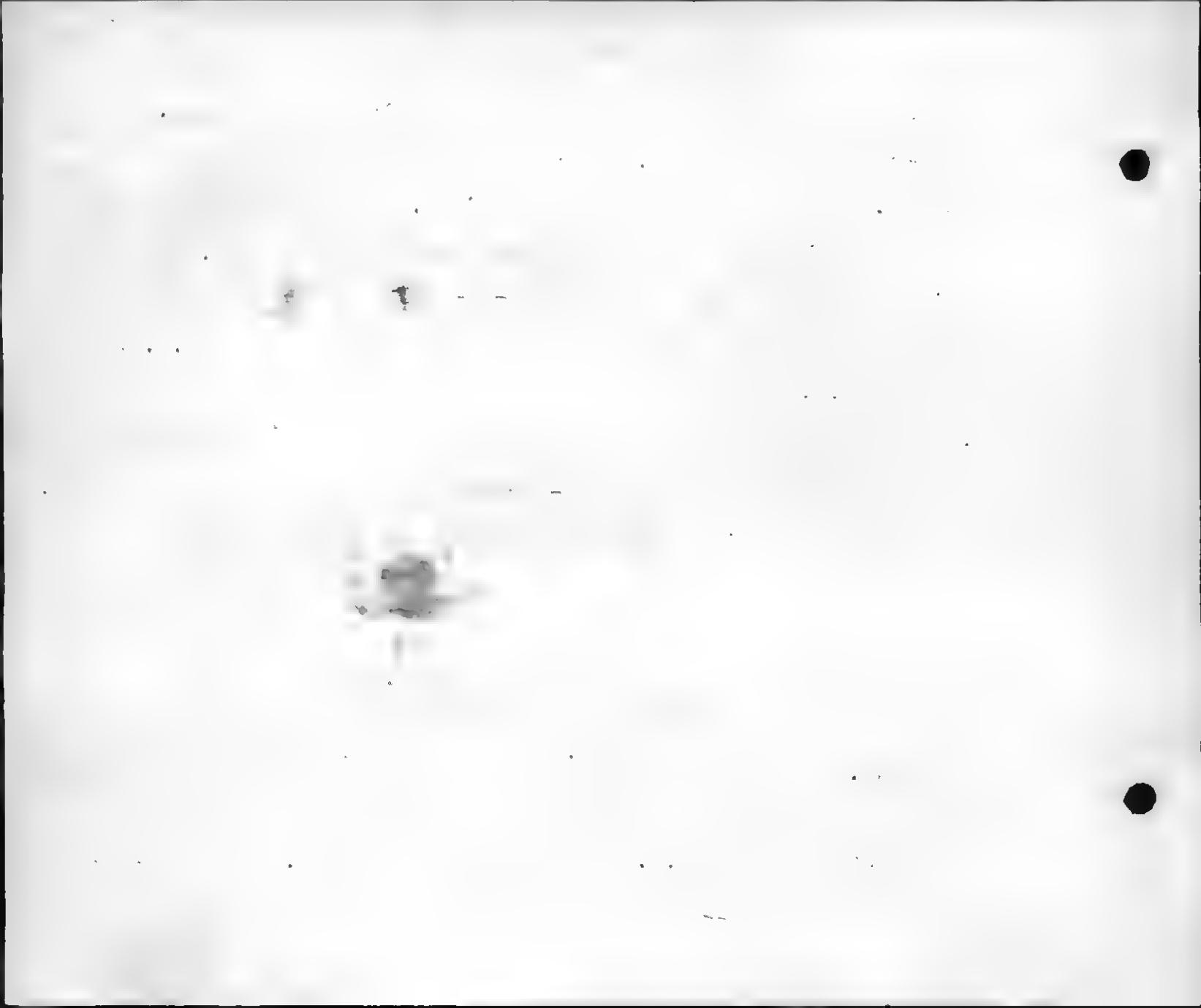
CERTIFICATE OF DEATH

00505

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending Physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b 4 mo. 20 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
3. NAME OF DECEASED (Type or print) Albina	4. DATE OF DEATH Last Praglowski	Month Jan.	Day 10	Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1896	9. AC 76 years 68 day yrs Months 23	10. IF UNDER 1 YEAR IF UNDER 24 HRS Hours 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Poland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Bilek	14. MOTHER'S MAIDEN NAME Anna Fialkowski				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO	INFORMANT Hospital	Address Sykesville		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X Acute Bronch-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Chronic Brain Syndrome of unknown cause DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 20, 1959, to Jan. 10, 1960, that I last saw the deceased alive on Jan. 9, 1960, and that death occurred at 4:45 P.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED M.D. Sykesville 1-10-60					
ACTUAL SIGNATURE <i>J. Flores</i>	PHYSICIAN'S NAME (Type) Joseph Flores, M.D.				
22a. BURIAL CREMATION Buried	22b. DATE THEREOF Aug 13/60	22c. NAME OF CEMETERY OR CREMATORIAL Rosary	22d. LOCATION (City, town, or county) Baltimore	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Fred W. O'Zagarski 1930 Eastern</i>	ADDRESS	24a. REC'D BY REGISTRAR JAN 12 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

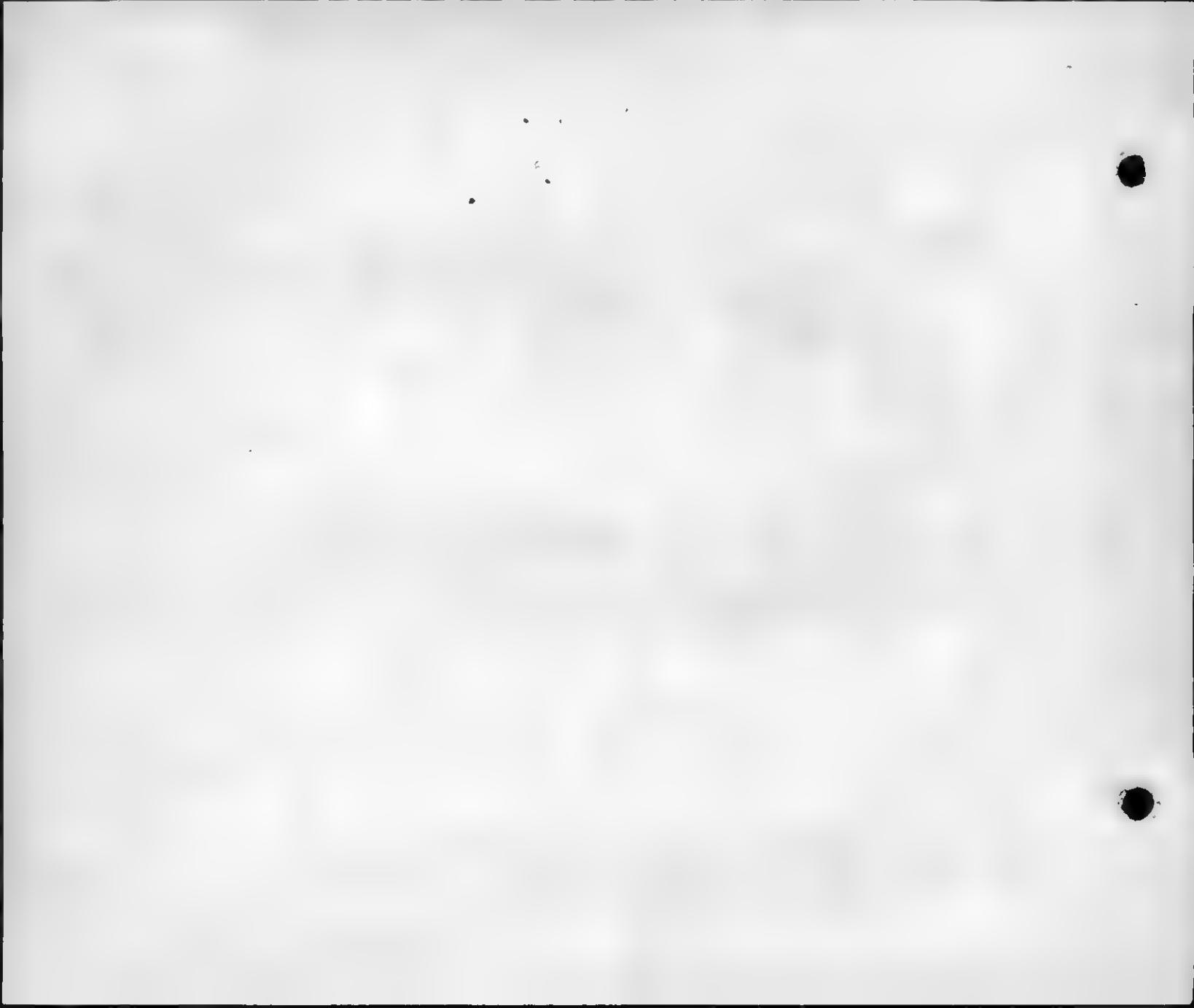
Reg. Dist. No.

00506

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 1 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		05-1		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		Circleville			
Hampstead (Burial)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hampstead			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		Rural			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
INFANT		BOY		PRATER	JAN	26	1960		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
M	LG		Jan 26-1960		yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
None		720		Maryland		U.S.A			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Paul R Prater		Beatrice Queenie							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		No		Evelyn Prater, Hampstead Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7620 ATALECTASIS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		DATE SIGNED 1/26/60							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-26-60	22c. NAME OF CEMETERY OR CREMATORIAL PLACE		22d. LOCATION (City, town, or county) 1846 7100			(State) 7620	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Evelyn Prater, Hampstead Md		24a. REC'D. BY REGISTRAR FEB 1 1960		24b. REGISTRAR'S SIGNATURE Evelyn Prater			
				DATE					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G254 1-4-60 et

0512

CERTIFICATE OF DEATH

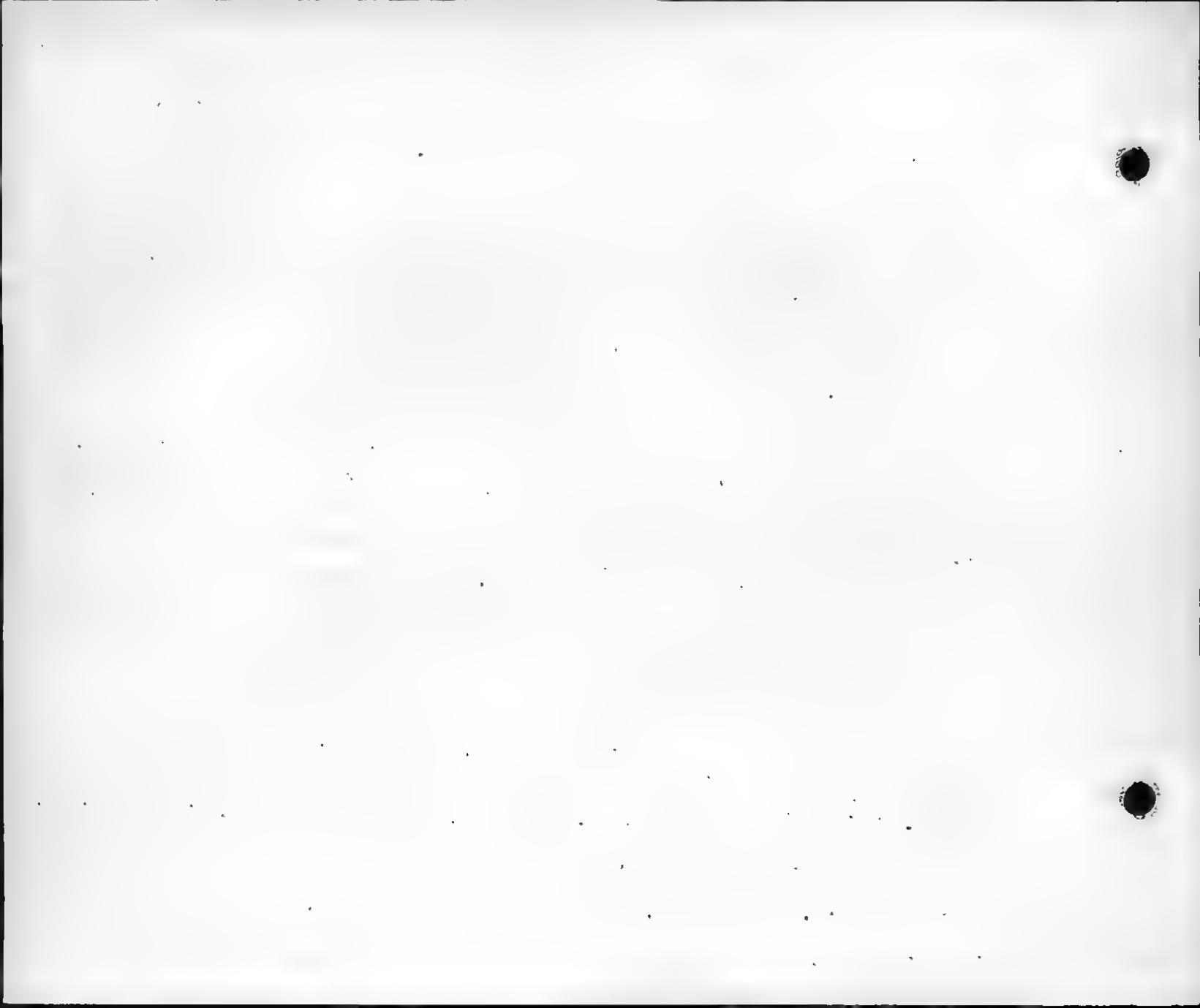
Reg. Dist. No.

00557

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster	
3. NAME OF DECEASED (Type or print) Emma		First I.	Middle Reifsneider
4. DATE OF DEATH January 13 1960	Month January	Day 13	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1878 December 8, 1877
			9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James F. Yingling		14. MOTHER'S MAIDEN NAME Elizabeth Waltman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Claude B. Reifsneider, Westminster, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mo	
Cerebral Hemorrhage Hypertension & arterio sclerotic 5-6 yrs Cardio Renal disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 16</u> , 1959, to <u>Jan 13</u> , 1960, that I last saw the deceased alive on <u>Jan 13</u> , 1960, and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city, or town, state) W. Glenn Speicher, Westminster, Md. DATE SIGNED 1/14/60	
ACTUAL SIGNATURE W. Glenn Speicher, Westminster, Md.			
PHYSICIAN'S NAME (Type) W. Glenn Speicher, Westminster, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Meadow Branch Cemetery		22d. LOCATION (City, town, or county) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son, Taneytown, Maryland		ADDRESS	
		24a. REC'D BY REGISTRAR DATE JAN 18 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0513

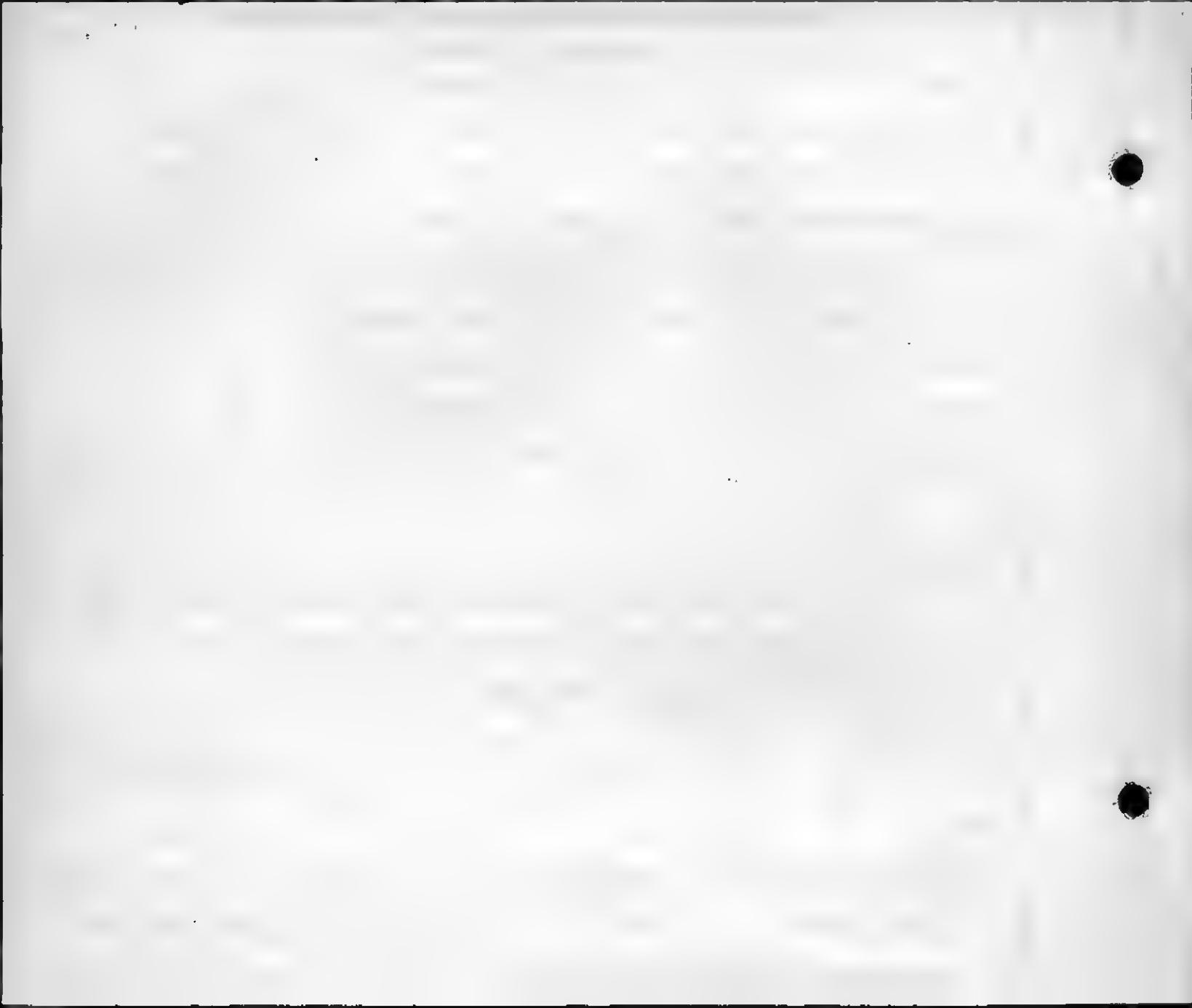
CERTIFICATE OF DEATH

Reg. Dist. No.

011508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>CHARLES</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>CHARLES</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>UNION BRIDGE</i>		c. LENGTH OF STAY IN 1b <i>YEARS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>UNION BRIDGE</i>		d. STREET ADDRESS <i>BENEDUM ST</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>BENEDUM ST</i>		d. STREET ADDRESS <i>BENEDUM ST</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>CAROLINE ELIZA RICKETTS</i>		First	Middle	Last	4. DATE OF DEATH <i>JAN. 21</i>	Month	Day	Year <i>1960</i>
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 1877</i>	9. AGE (In years last birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEKEEPER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>WILLIAM FRITZ</i>		14. MOTHER'S MAIDEN NAME <i>EMMA MOPPS</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-40-5268</i> 17. INFORMANT <i>Mrs. Wilson Harris</i> Address <i>Union Bridge</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis.</i>		DUE TO <i>45.0.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. <i>(b)</i>		DUE TO <i>(c)</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Right hemiparesis. Right renal calculus; aortic stenosis</i>				19. WAS AUTOPSY PERFORMED? <i>NO</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>5:30 AM</i>						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Union Bridge</i>	(County) <i>Charles</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>1/15/60</i> , 1959, to <i>1/21/60</i> , 1960, that I last saw the deceased alive on <i>1/21/60</i> , 1960, and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Union Bridge, Md.</i>		DATE SIGNED <i>1/21/60</i>		
ACTUAL SIGNATURE <i>J. H. Carleff</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>J. H. CARLEFF</i>		UNION BRIDGE, MD.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>1/24/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>LINGANORE CEM</i>	22d. LOCATION (City, town, or county) <i>UNIONVILLE MD</i>			(State) <i>MD</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 25 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0465 CERTIFICATE OF DEATH

00593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN 1b <i>4 yrs</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>68½ Bond St.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>				
d. STREET ADDRESS <i>68½ Bond St.</i>		d. STREET ADDRESS <i>68½ Bond St.</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>MAGGIE ESTELLE RINEHART</i>		First	Middle			
4. DATE OF DEATH <i>JAN. 20</i>		Month	Day			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>Nov. 29 1876</i>		9. AGE (In years less birthday) <i>83</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or Foreign country) <i>Carroll Co. Md.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John T. Hesson</i>				
14. MOTHER'S MAIDEN NAME <i>Mary Harmer</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>				
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>C. EARL RINEHART, Westminster, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A. S. C. V DISEASE</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>1 YEARS</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>1955</i> to <i>1-20</i> , 1960, that I last saw the deceased alive on <i>1-20</i> , 1960, and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>—</i>						
ACTUAL SIGNATURE <i>James T. Marsh</i>		M.D.		DATE SIGNED <i>1-21-60</i>		
PHYSICIAN'S NAME (Type) <i>JAMES T MARSH</i>		WESTMINSTER MD				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 23, 60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Pine Creek Cemetery New Windsor, Md. R.D.</i>	22d. LOCATION (City, town, or county) (State) <i>—</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. S. Myers, Jr., Westminster, Md.</i>		ADDRESS <i>—</i>	24a. REC'D. BY REGISTRAR <i>25 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be received by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

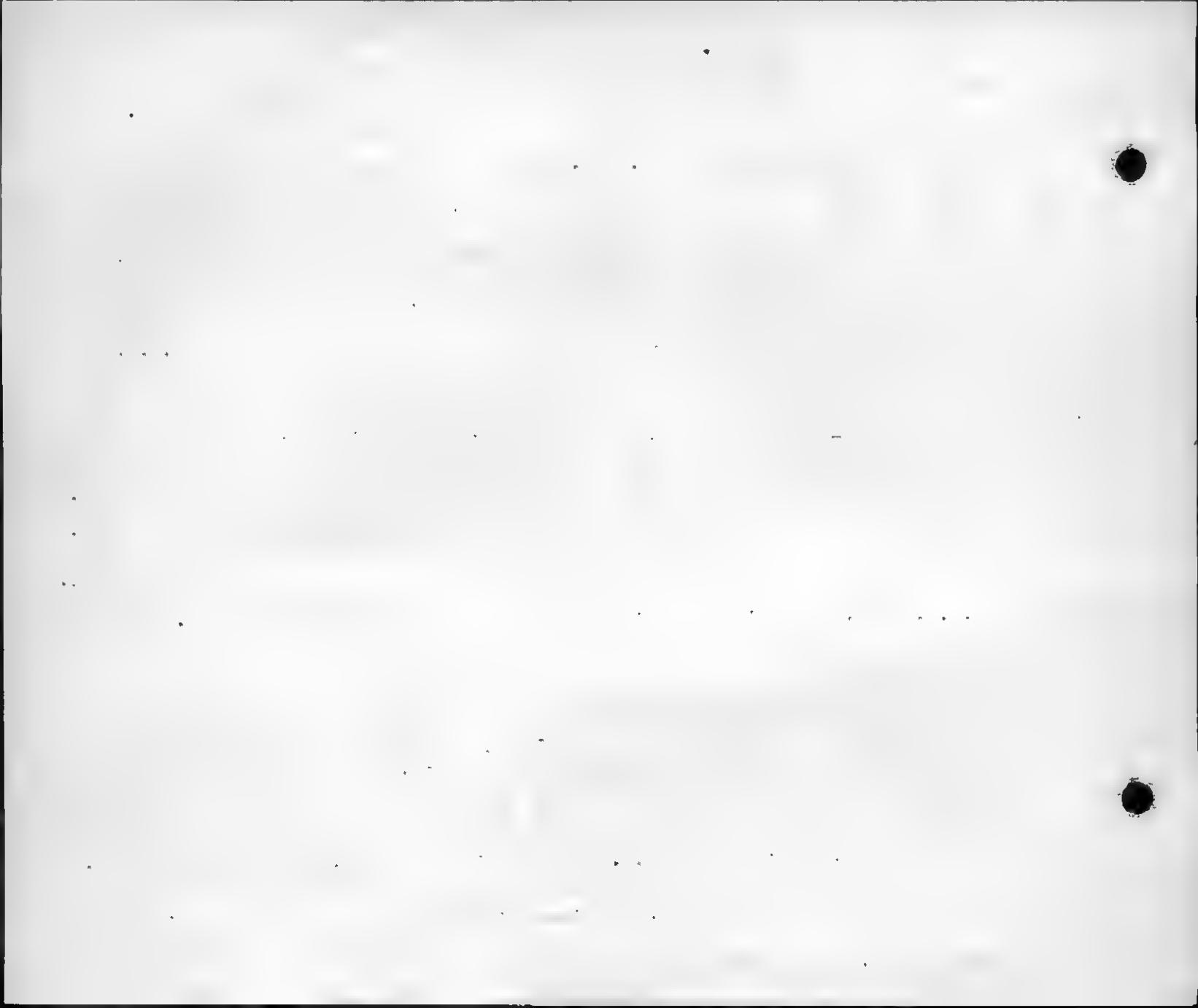
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0514

CERTIFICATE OF DEATH

00510

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 yrs. 8 mos. 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14		3. VITAL 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 4307 Mainfield Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Dunn	4. DATE OF DEATH January 24, 1960	Month Year	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH October 16, 1872	9. AGE (In years last birthday) 87	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Months 0	12. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Dunn		14. MOTHER'S MAIDEN NAME Cornelia Rickey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial tamponade							
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b)		Rupture of left descending coronary artery		24 hrs.	
		DUE TO (c)		Recent myocardial infarction		3 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 9, 1957 to January 24, 1960 , that (I) (we) last saw the deceased alive on January 24, 1960 and that death occurred at 12:30 P.M. on the causes and on the date stated above							
22a. SIGNATURE <i>Agustin del Campo</i>		M. D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/25/60			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.					
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/26/60		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 26 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0515 CERTIFICATE OF DEATH

00511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE M.D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINOBORO		b. COUNTY CARROLL	
c. LENGTH OF STAY IN 1b 14 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINOBORO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MINNIE WARNER		First MINNIE	Middle WARNER
4. DATE OF DEATH JAN. 22		Month JAN.	Day 22
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH OCT. 18, 1881		9. AGE (In years lost birthday) 78 yr.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPING		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) CARROLL Co. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME HENRY F. WARNER	
14. MOTHER'S MAIDEN NAME LYDIA MILLER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO 217-18-7388		17. INFORMANT Wm. J. L. RUPP	Address LINOBORO, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) General Arteriosclerosis DUE TO (c) Diabetes Mellitus 3-4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19, 36 to Jan. 22, 1960 , that I last saw the deceased alive on January 22, 1960 , and that death occurred at 3:20 p.m. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hampstead, Md. DATE SIGNED 1-23-60	
ACTUAL SIGNATURE M. C. Porterfield M.D.		PHYSICIAN'S NAME (Type) M. C. Porterfield	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 25, 1960	22c. NAME OF CEMETERY OR CREMATORIUM UNION
22d. LOCATION (City, town, or county) LINOBORO, M.D.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Craypole & Son		24a. ADDRESS Glen Rock, Pa.	24b. REGISTRAR'S SIGNATURE Orinus S. Evans
24a. REC'D BY REGISTRAR JAN 27 '60		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

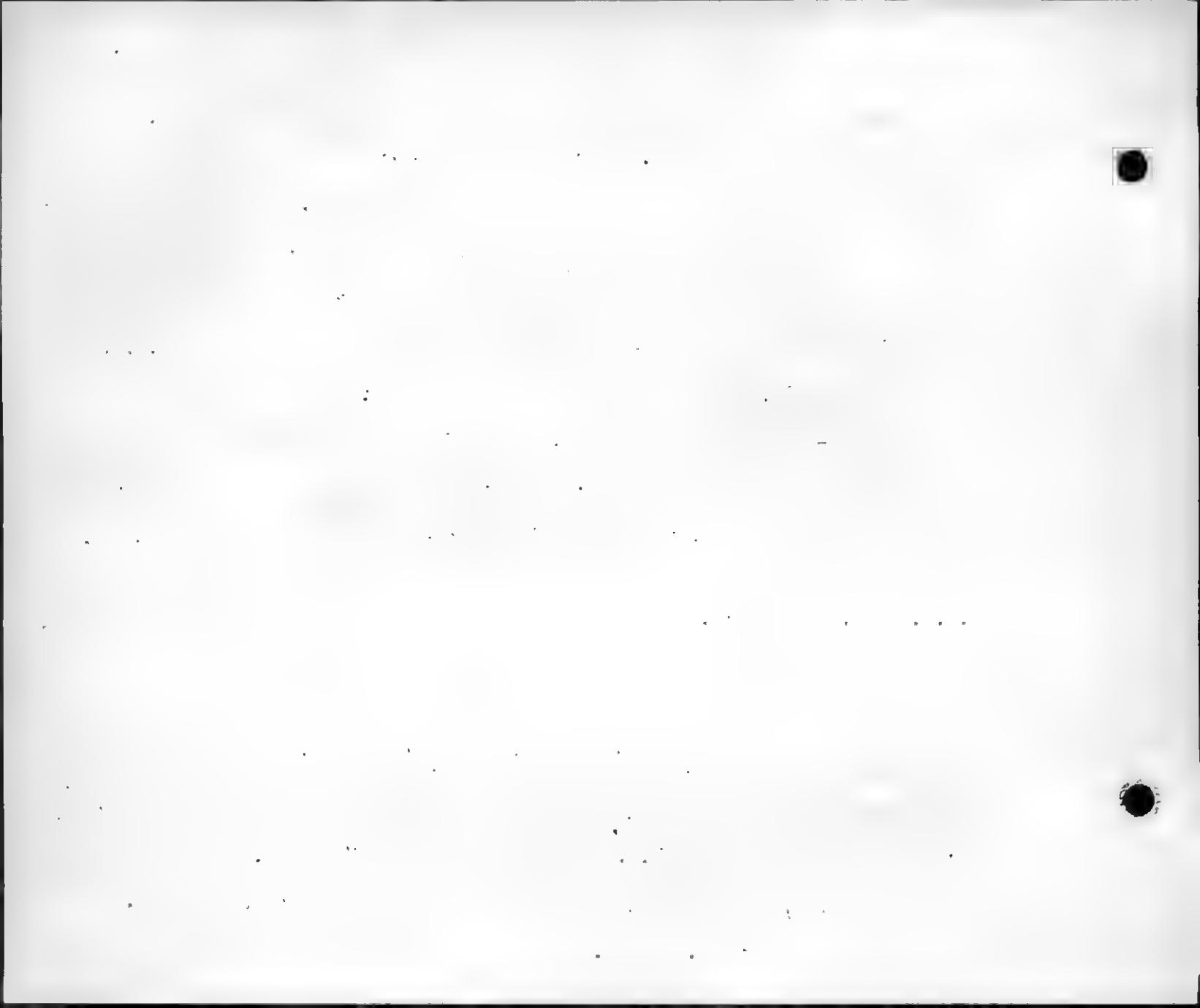
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0510 CERTIFICATE OF DEATH

Reg. Dist. No. 00512

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3mos. 27days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24	
3. NAME OF DECEASED (Type or print) Joseph		d. STREET ADDRESS 3227 Fait Ave.	
4. DATE OF DEATH January 6, 1960		Month	Day
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 13, 1890	
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler maker		10b. KIND OF BUSINESS OR INDUSTRY -	
10c. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanislaus Rychwalski		14. MOTHER'S MAIDEN NAME Barbara Pietrowiez	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-arteriosclerosis			
DUE TO 334X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis			
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) C.B.S. assoc. with trauma.			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1959 , to January 6, 1960 that I last saw the deceased alive on January 5, 1960 , and that death occurred at 2:10AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED 1/6/59			
MEDICAL CERTIFICATION			
ACTUAL SIGNATURE Agustin del Campo			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 9, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus		22d. LOCATION (City, town, or county) Dundalk Ave. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 2829 Hudson St. 24, Md.		24a. REC'D BY REGISTRAR DATE JAN 7 '60	
ADDRESS John J. Duda 2829 Hudson St. 24, Md.		24b. REGISTRAR'S SIGNATURE Orlina S. Tins	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Carroll</i> MARYLAND		<i>Mayfield Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>WILLIAM - ROSS - SHOWER</i>		Last	4. DATE OF DEATH Jan 1 1960
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 20-1887</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General</i>	
10c. BIRTHPLACE (State or foreign country) <i>Md</i>		11. AGE (In years last birthday) <i>72 yr.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William H Shower</i>	
14. MOTHER'S MAIDEN NAME <i>May Ross</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>220-16-4093 - Mrs May. R. Shower Manchester, Md</i>		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		- <i>Acute Renal Failure</i> <i>Antemortem heart Disease 5 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cirrhosis in Liver</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec</i> , 1950, to <i>Jan 1</i> , 1960, that I last saw the deceased alive on <i>Dec 31</i> , 1959, and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Manchester, Md</i> DATE SIGNED <i>1/2/60</i>	
ACTUAL SIGNATURE <i>W H Shower</i>		PHYSICIAN'S NAME (Type) <i>W H Shower MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 3/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Manchester</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie Sipton Hampstead Md</i>		22d. LOCATION (City, town, or county) (State) <i>Carroll Co Md</i>	
ADDRESS <i>Edie Sipton Hampstead Md</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 4 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0517

CERTIFICATE OF DEATH

Reg. Dist. No.

00514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this cert. ficate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Carroll				a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY	City
Sykesville		11yrs. 11mos. 22days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		d. STREET ADDRESS	
Springfield State Hospital		1915 Breitwert Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Martha	Middle Elizabeth	Last Sifter	4. DATE OF DEATH	Month January Day 9, Year 1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	February 23, 1919	40 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None		-		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Sifter		Caroline - Mayer		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT	
No		NONE		Springfield Hospital Records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
33IX DUE TO Bronchopneumonia					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebralvascular accident (old)					
Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) Mental deficiency, imbecile level without psychosis, plus epilepsy.					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1955, to January 9, 1960, that I last saw the deceased alive on January 9, 1960, and that death occurred at 3:00 P.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
DATE SIGNED					
ACTUAL SIGNATURE: Agustin del Campo					
M.D. Springfield State Hospital 1/9/60					
PHYSICIAN'S NAME (Type)		Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)
Burial		13 Jan 1960	WESTERN Cem		BALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Edward Toulson		1359 Wash Blvd		DATE JAN 11 '60	Charles S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

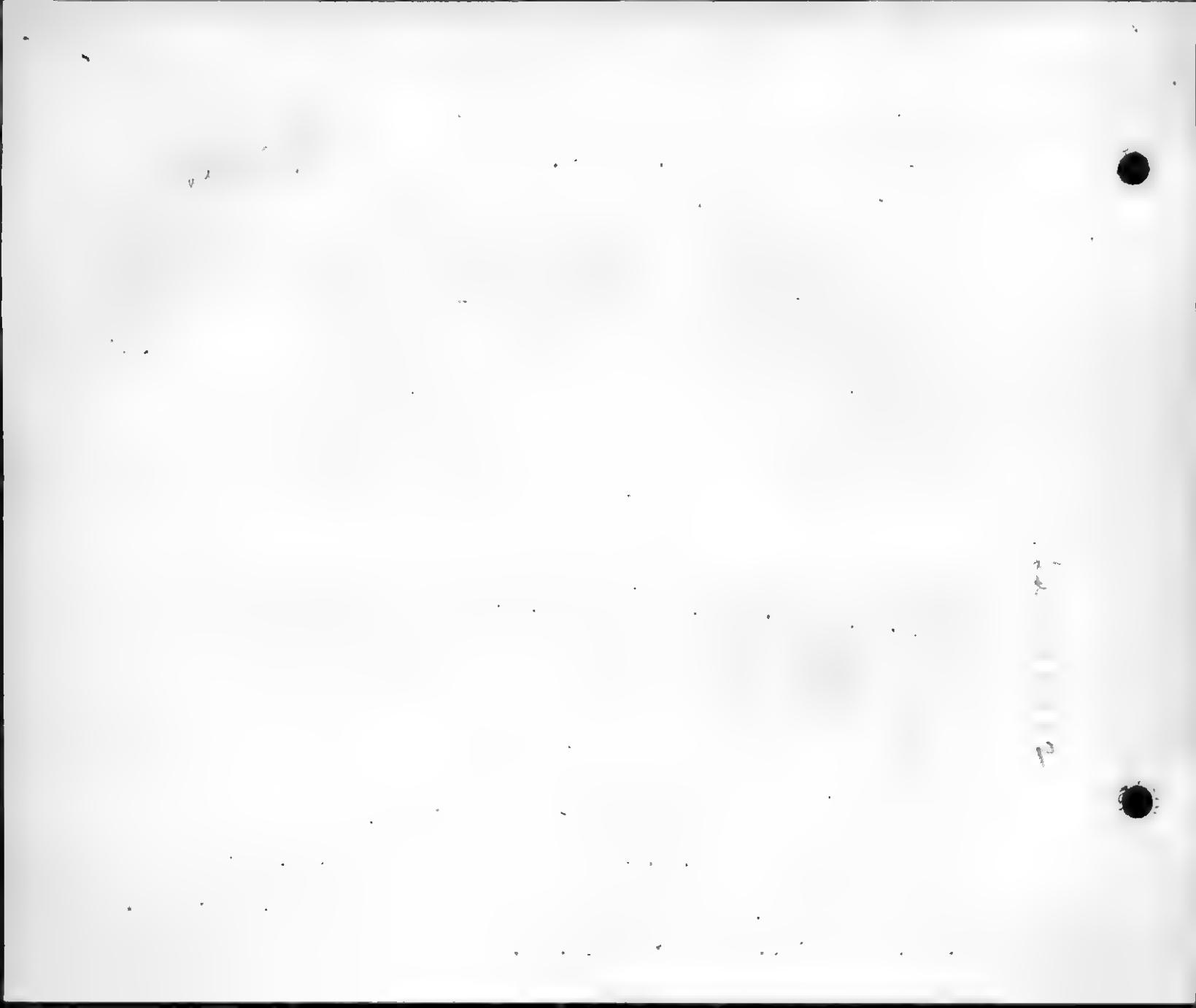
Item 2-Phone t MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Undertaker 2-9-60 and 00515.

0518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)		c. LENGTH OF STAY IN lb Byr. 6m. 20d.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Lillian		First Middle Loane	4. DATE OF DEATH Month 1 Day 29 Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gustave Loane		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Springfield State Hospital record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 422.1 DUE TO Heart failure			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardiovascular disease			
DUE TO (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, associated with disturbance of metabolism growth or nutrition, with senile brain disease with psychotic reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 18, 1958, to 1-29, 1960, that I last saw the deceased alive on 1-29, 1960, and that death occurred at 7:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oak Street DATE SIGNED			
ACTUAL SIGNATURE Konstantin Weber, M.D.			
PHYSICIAN'S NAME (Type) Konstantin Weber, M.D.			
Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-1-60	
22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. 14.		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
		24b. REGISTRAR'S SIGNATURE Lorraine L. Isaac	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0519 CERTIFICATE OF DEATH

00516

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 9mths. 28days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Adam	Last Smith
4. DATE OF DEATH	Month 1	Day 30	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-1884
9. AGE (In years at birthday) 75	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Smith		14. MOTHER'S MAIDEN NAME Catherine France	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-14-6729	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: Myocardial Infarction INTERVAL BETWEEN IMMEDIATE CAUSE (a) ONSET AND DEATH days			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) days			
DUE TO Hypertensive arteriosclerotic heart disease (c) years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY Chronic brainsyndrome asso. with cerebral arteriosclerosis PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-2- 1957 to 1-30- 1960 , that (I) (we) last saw the deceased alive on 1-30- 1960 , and that death occurred at 10.35 p.m. from the causes and on the date stated above			
22a. SIGNATURE <i>Agustin del Campo.</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 1-31-60
22c. PHYSICIAN'S NAME (Type) Agustin del Campo.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 1 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery Belair Road Bel Air		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Leo S. Cook 1701 Patterson Ave.		ADDRESS 1701 Patterson Ave.	25a. REC'D BY REGISTRAR FEB 1 '60
			25b. REGISTRAR'S SIGNATURE Agustin S. Campo



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
0520 CERTIFICATE OF DEATH

00517

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)	
Carroll		a. STATE <input checked="" type="checkbox"/> Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY <input checked="" type="checkbox"/> Carroll	
Alyerville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b 3 1/2 years		d. STREET ADDRESS x Alyerville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 Oak St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Charles William Smith		Smith	Lost
4. DATE OF DEATH		Month	Day
		Jan.	19
		1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	B. DATE OF BIRTH March 19 1902
8. AGE (In years last birthday) 57 yrs		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Harvey Smith		14. MOTHER'S MAIDEN NAME Ella Heathley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ethelde Smith - Alyerville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1957 and 19 Jan 60	
DUE TO Diseas, alcoholism severe (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ AM, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE Howard E. Hall		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Howard E. Hall		22d. ADDRESS Alyerville, Md. 20 Jan 60	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-22-60	
23c. NAME OF CEMETERY OR CREMATORIAL New Oakland		23d. LOCATION (City, town, or county) Oakland Rd. Carroll Co., Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Lester H. Haught		25a. REG. BY REGISTRAR JAN 22 60	
ADDRESS Alyerville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Tracy	

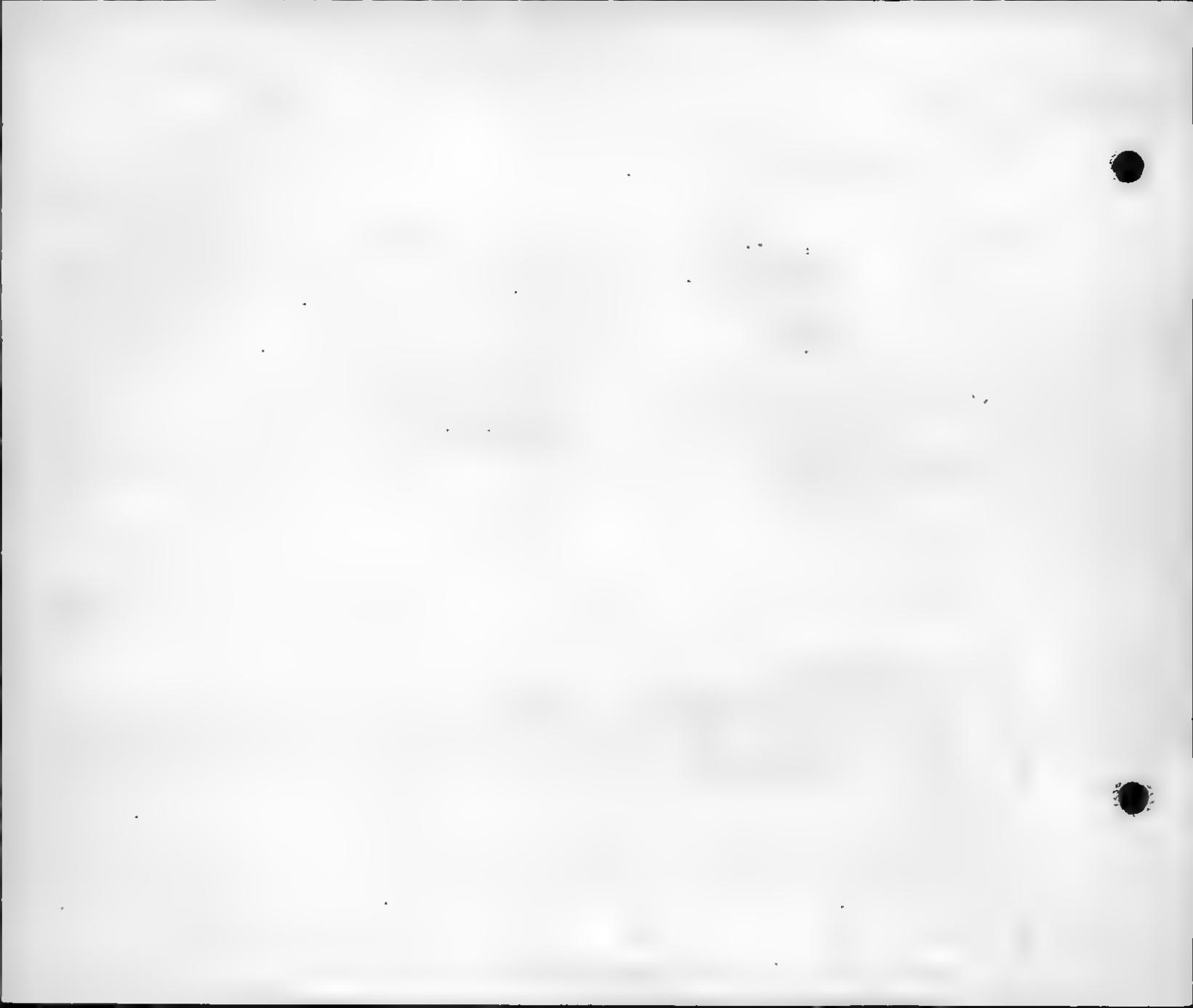


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00518

1. PLACE OF DEATH a. COUNTY CARROLL		55 JUN 1 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		c. LENGTH OF STAY IN 1b 64 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NEAR DENNINGS		d. STREET ADDRESS NEAR DENNINGS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) GLERNIE		First L.	Middle STULLER	Last STULLER	4. DATE OF DEATH JAN. 16	Month 1960	Day 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 3, 1895	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WESTMINSTER, MD. RD#1						
13. FATHER'S NAME JESSE T. STULLER		14. MOTHER'S MAIDEN NAME LEANNAH LINDSAY								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 215-36-8185		17. INFORMANT MRS. GL. STULLER, WESTMINSTER, MD. RD#5		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 289.1		HEMORRHAGE FROM BLADDER		INTERVAL BETWEEN ONSET AND DEATH 1 DAY						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. —		(b) AMYLOID INFILTRATION OF LIVER		6 MOS						
(c) PRIMARY AMYLOIDOSIS				2 YEARS						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 19 RIDGE RD.	(County) WESTMINSTER, MD.	(State) MD.				
21. I certify that I attended the deceased from MARCH 17, 1959 to JANUARY 16, 1960 , that I last saw the deceased alive on JANUARY 16, 1960 , and that death occurred at 249 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE William T. Stewart, M.D.		ADDRESS (Street, city or town, state) 19 RIDGE RD.		DATE SIGNED 1/16/60						
PHYSICIAN'S NAME (Type) WILLIAM L. STEWART		WESTMINSTER, MD.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 19, 1960	22c. NAME OF CEMETERY OR CEMETORY ST. JAMES CEMETERY	22d. LOCATION (City, town, or county) WESTMINSTER, MD. RD#5	(State) MD.					
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Meyer, Jr., Westminster, Md.		ADDRESS —		24a. REC'D BY REGISTRAR DATE 20 '60	24b. REGISTRAR'S SIGNATURE —					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00513

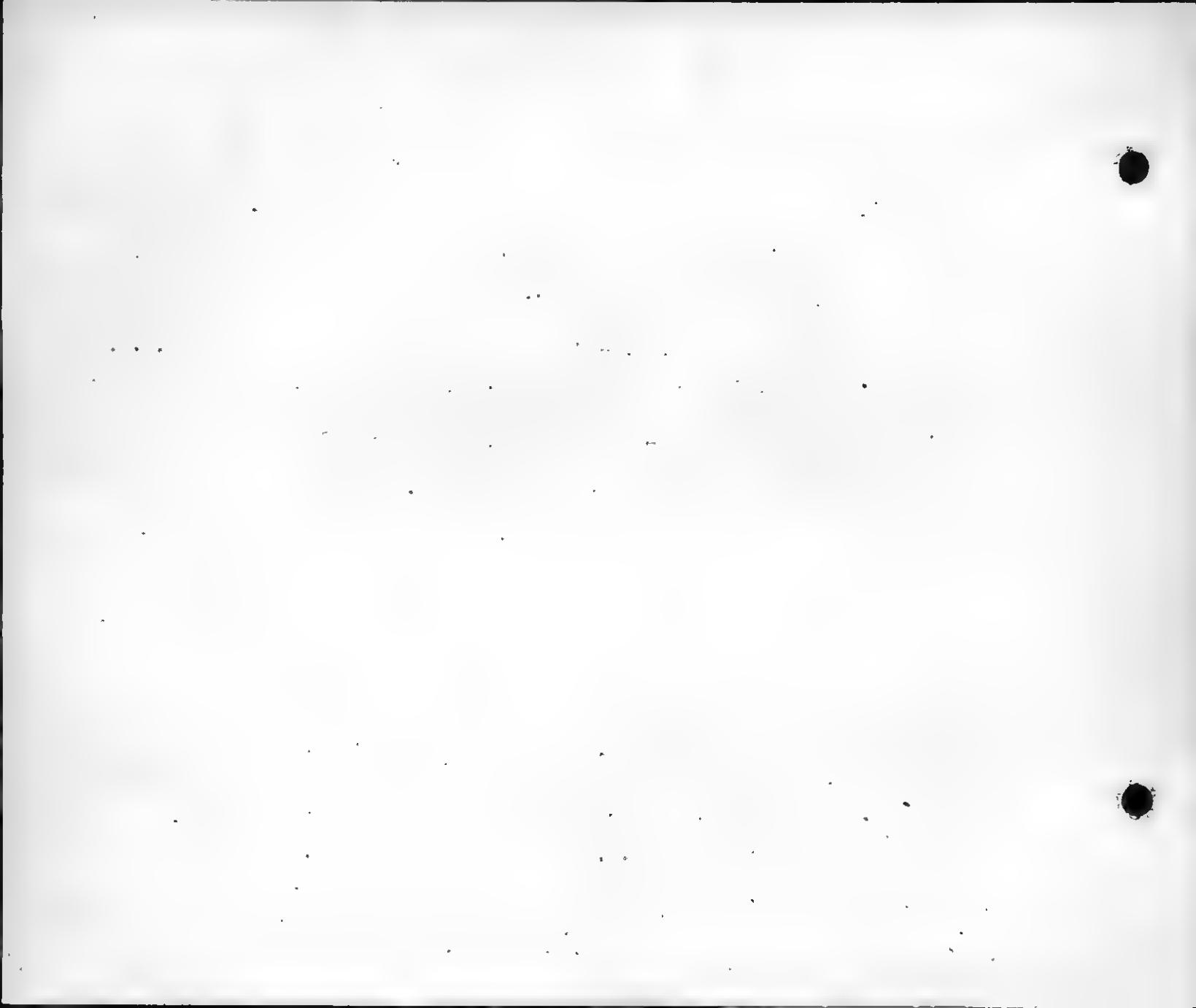
0522 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle	Last Thiernau
4. DATE OF DEATH	Month January	Day 3,	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 2/27/83
9. AGE (In years last birthday) 76 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Unknown John Thiernau		
14. MOTHER'S MAIDEN NAME Unknown Adelade Schurde	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. No	INFORMANT -	Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction			
DUE TO 400.1			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary arteriosclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 27, 1959, to January 3, 1960, that I last saw the deceased alive on January 3, 1960, and that death occurred at 5:15 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustín del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 1/4/60	
PHYSICIAN'S NAME (Type) Agustín del Campo, M.D.		Sykesville, Md.	
22a. BURIAL, CREMATION REMOVAL (Specify) Funeral	22b. DATE THEREOF 1/6/60	22c. NAME OF CEMETERY OR CREMATORIUM Wash. Hill	22d. LOCATION (City, town, or county) Sykesville
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Chambers	ADDRESS 1000 Chelmsford St. B.	24a. REC'D BY REGISTRAR JAN 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0400

CERTIFICATE OF DEATH

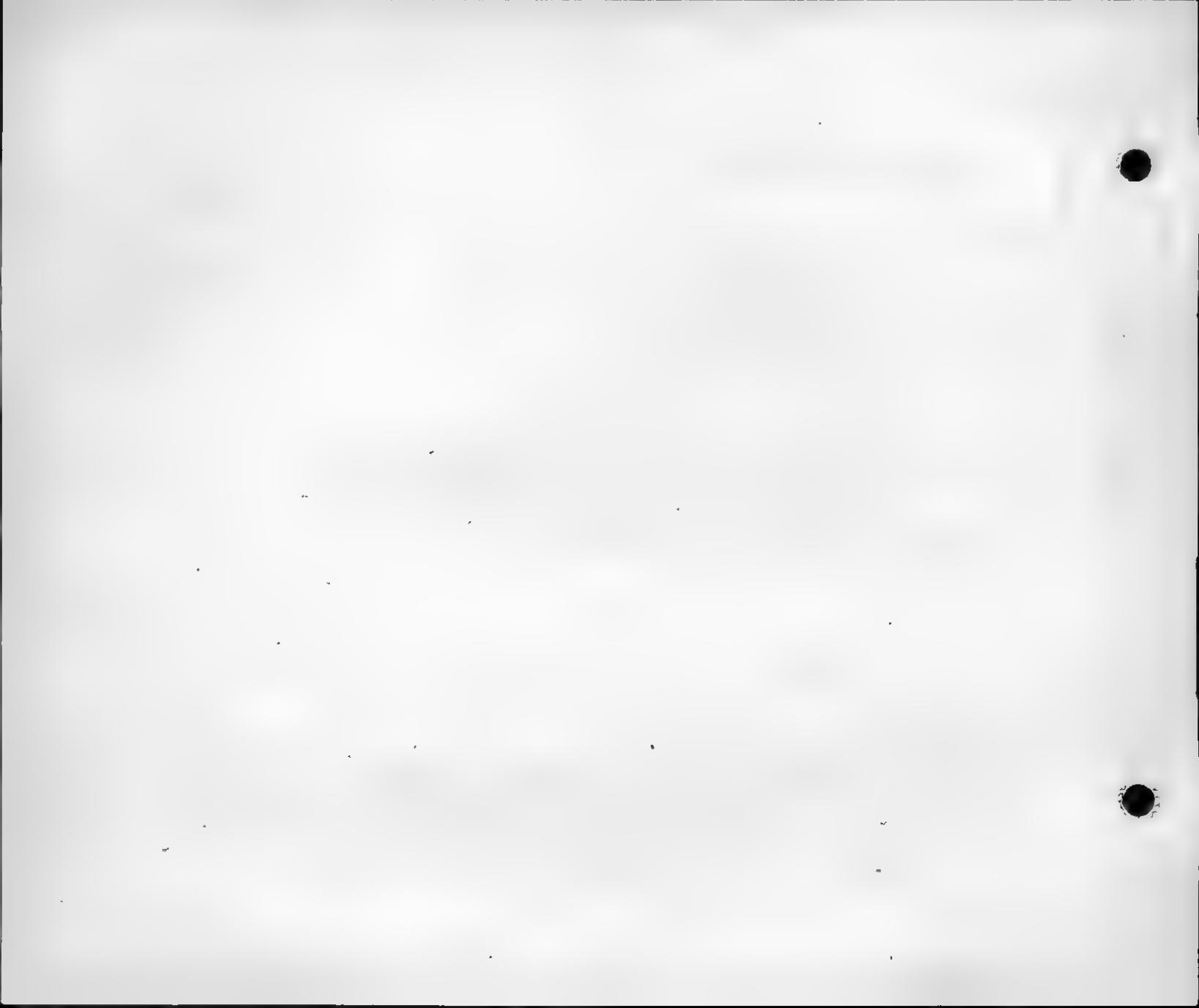
Reg. Dist. No.

00520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE		Md.		b. COUNTY		Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister		c. LENGTH OF STAY IN 1b 6 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister		d. STREET ADDRESS 820 E. Baltimore Blvd.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Bertha	Middle E.	Lost	4. DATE OF DEATH Jan. 14 1960	Month Jan.	Day 14	Year 1960				
5. SEX F.		6. COLOR OF RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1883	9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY U. S. A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U. S. A.						
13. FATHER'S NAME Samuel Fengerfelter		14. MOTHER'S MAIDEN NAME Janie Lucken		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 44-12-1212		17. INFORMANT Dr. Edward L. Tillman		Address above.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		420.1		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 15 minutes		
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b)		Mycarditis- Decompensating few years						
		DUE TO Hypertension + Arteriosclerosis		(c)						57/55		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1-1-45 to 1-14-60, that I last saw the deceased alive on 1-12-1960, and that death occurred at 1:30 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE James G. Saffell M.D.		ADDRESS (State, city or town, state)		DATE SIGNED 1-14-60						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		Signature				
Burial		1-16-60		New Carrollton		New Carrollton, Carroll Co. Md.						
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE						
Arthur H. Haight, Hyattsville, Md.		ADDRESS		REC'D BY REGISTRAR JAN 19 '60		REGISTRAR'S SIGNATURE Arthur S. Hause						



TO HOSPITAL OR HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

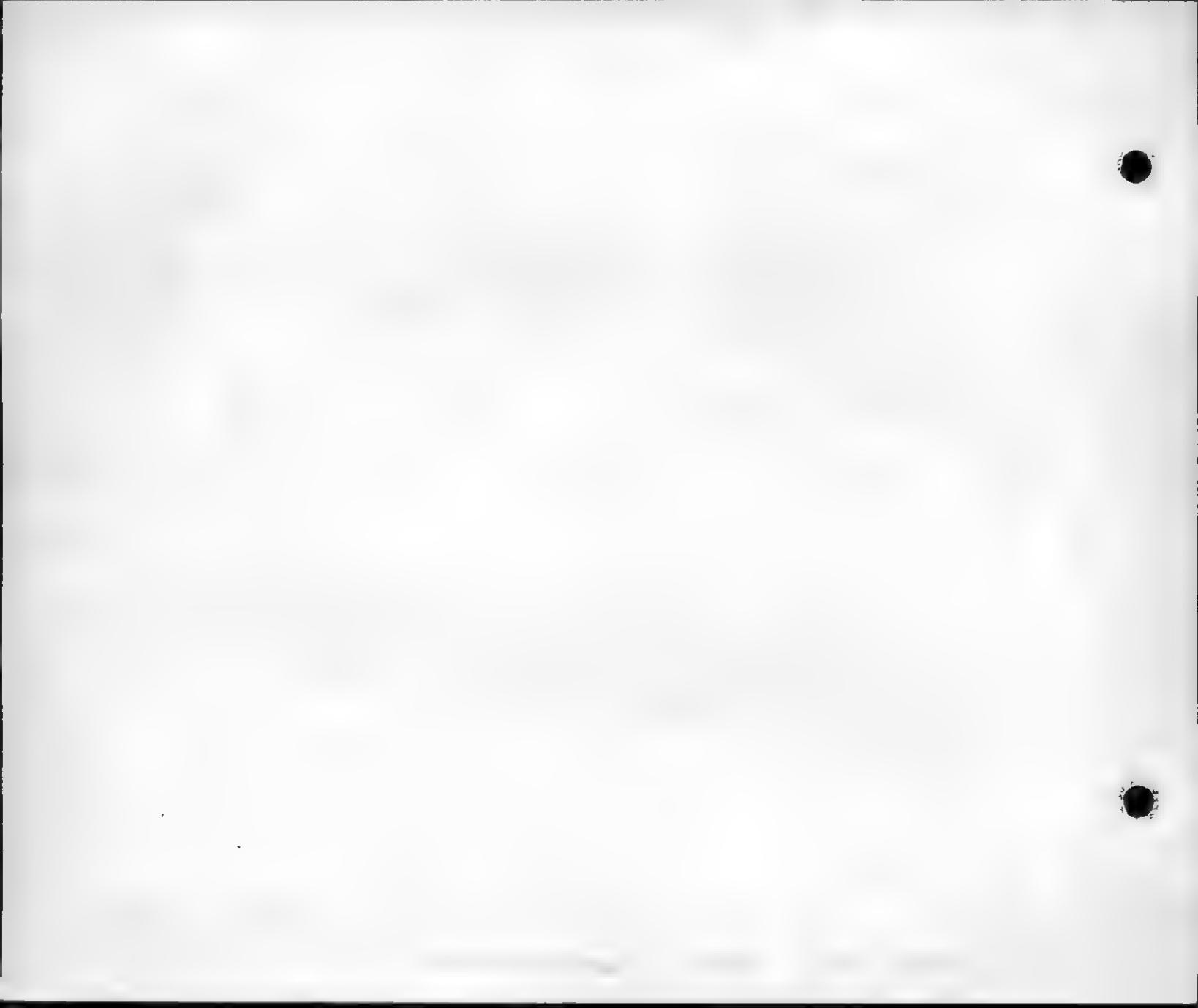
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0522

CERTIFICATE OF DEATH

Reg. Dist. No. 00521

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Carroll</i> <i>Longmeadow Rd.</i>		Md. <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Appleville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Appleville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION		d. STREET ADDRESS <i>Longmeadow Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>William H. Tillman</i>	Middle Last
4. DATE OF DEATH		Month Jan	Day 13
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male		White	7/17/1898
9. AGE (In years (last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
61 yrs		Months	Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Police Dept.</i>		<i>Balto. City</i>	
10c. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Chas. W. Tillman</i>		<i>Corrie H. Boyd</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes		W.W.I 213-28-1692 Lorraine C. Piotola	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INFORMANT Address	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		CORONARY OCCLUSION	
4.1.1 DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 MIN.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		5 MIN.	
(b) DUE TO		10 YRS	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JAN. 3, 1955</i> to <i>JAN. 13, 1960</i> , that I last saw the deceased alive on <i>DEC. 14, 1959</i> , and that death occurred at <i>1:05 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>401 RANDOM ROAD</i> DATE SIGNED <i>1/14/60</i>	
ACTUAL SIGNATURE <i>John F. Schaefer</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>John F. Schaefer</i>		BAKTO. 29 MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/18/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i>		22d. LOCATION (City, town, or county) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. MacNabb & Son, Patowmack</i>		ADDRESS <i>28</i>	
		24a. REC'D BY REGISTRAR <i>JAN 15 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0524

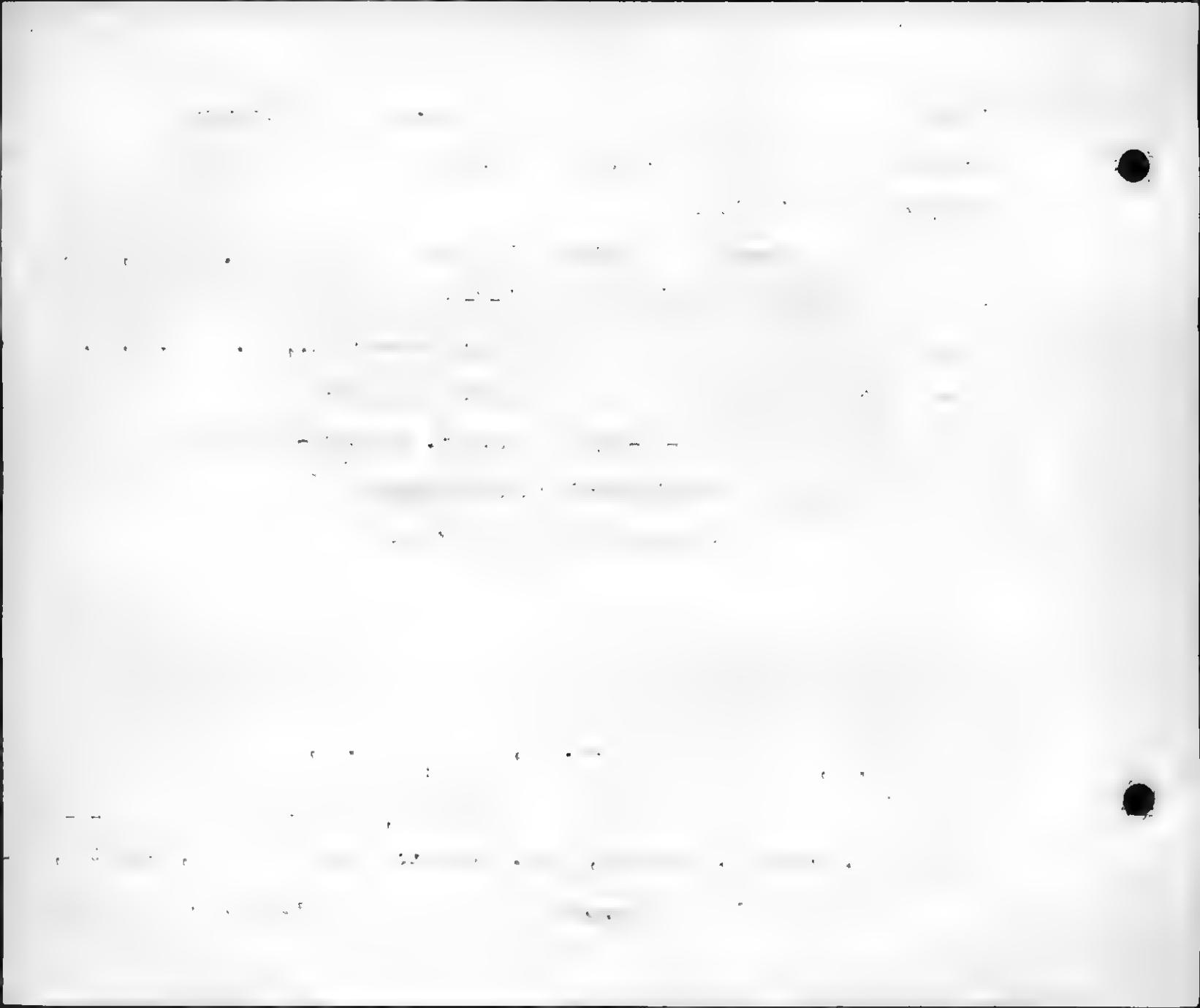
CERTIFICATE OF DEATH

Reg. Dist. No. 00522

TO HOSPITAL OR HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk		d. STREET ADDRESS 041		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James William Wallace		First James	Middle William	Last Wallace	4. DATE OF DEATH Jan. 4, 1960	Month Jan.	Day 4	Year 1960
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPX DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-1903		9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Wallace				14. MOTHER'S MAIDEN NAME Henrietta Creek				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. 212-12-4958		INFORMANT James Wm. Wallace - Patient		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO								
Cardiovascular insufficiency								
Carcinoma of the right lung								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Dec. 16, 1959 , to Jan. 4, 1960 , that I last saw the deceased alive on Jan. 4, 1960 , and that death occurred at 11:00 p.m. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Edgars M. Maculans, M.D., Henryton, Maryland								
DATE SIGNED 1-4-60								
ACTUAL SIGNATURE <i>Edgars M. Maculans</i>								
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-7-60		22b. DATE THEREOF 1-7-60		22c. NAME OF CEMETERY OR CREMATORIUM Wesley		22d. LOCATION (City, town, or county) 74 Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE P. C. Sewell Prince Frederick Md.								
ADDRESS DATE JAN 12 '60								
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE								



0525 CERTIFICATE OF DEATH

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton, Maryland		c. LENGTH OF STAY IN 1b 224 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		d. STREET ADDRESS Route 2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Raymond	First Raymond	Middle Savaniel	Last Warner	4. DATE OF DEATH January	Month 5	Day 19	Year 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-1897	9. AGE (in years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months 62	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Trappe, Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John Warner		14. MOTHER'S MAIDEN NAME Rosa McLaughlin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT Raymond S. Warner - Patient	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Chronic Lymphatic leukemia DUE TO (c) Pleurisy with effusion left. INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 26 , 19 59 , to Jan. 5 , 19 60 , that I last saw the deceased alive on January 5 , 19 60 , and that death occurred at 3 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Trappe, Maryland DATE SIGNED 1-5-1960								
ACTUAL SIGNATURE <i>Rodgers M. Maculans, M.D.</i>		M.D.		1-5-1960				
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.		Henryton State Hospital						
22a. BURIAL, CREMATION REMOVAL (Specify) 1-10-60		22b. DATE THEREOF 1-10-60		22c. NAME OF CEMETERY OR CREMATORIAL Trappe, Md.		22d. LOCATION (City, town, or county) Trappe		(State) md
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Daill Easton, M.D.</i>		ADDRESS <i>Trappe, Md.</i>		24a. REC'D BY REGISTRAR JAN 11 '60		24b. REGISTRAR'S SIGNATURE <i>Charles S. Knobell</i>		

1960-1961
1961-1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

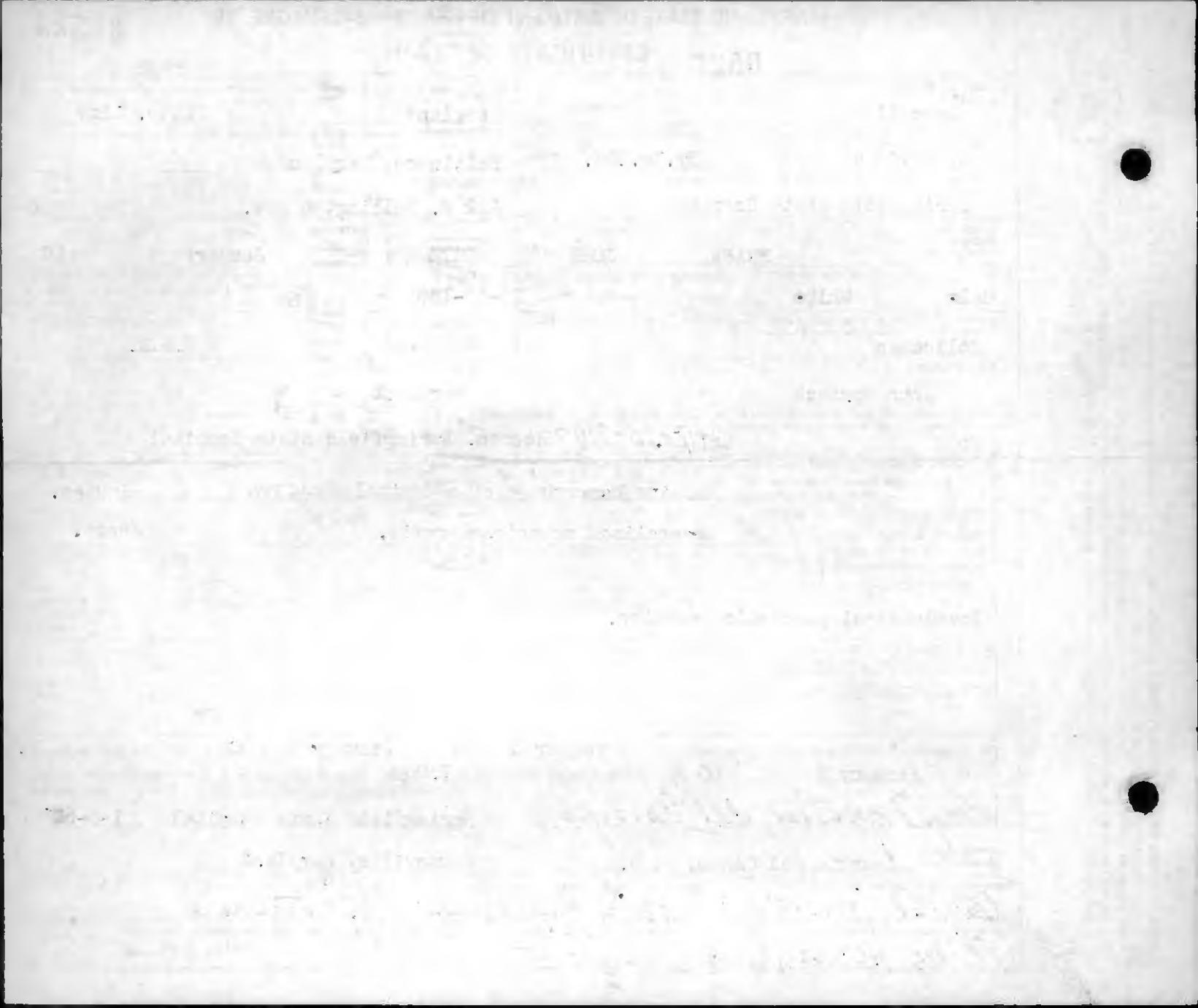
00524

0526

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3y. 1m. 29d.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. STREET ADDRESS 222 N. Collington Ave.		d. STREET ADDRESS 3801-4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRANK	Middle JOHN	Last WORTECK
4. DATE OF DEATH	Month January	Day 5	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-1893
9. AGE (In years last birthday) 66	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Months 0	12. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Worteck	14. MOTHER'S MAIDEN NAME Margaret		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-26-2197	INFORMANT Records, Springfield State Hospital	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage of abdominal aneurysm			
DUE TO 451X			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis.			
DUE TO (c)			
Years.			
INTERVAL BETWEEN ONSET AND DEATH Minutes.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Involutional psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore	(County) Baltimore	(State) Maryland	
21. I certify that I attended the deceased from November 6, 1956 , to January 5, 1960 , that I last saw the deceased alive on January 5, 1960 , and that death occurred at 7:00 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 1-5-60	
ACTUAL SIGNATURE <i>Agustin del Campo</i>	M.D.	22d. LOCATION (City, town, or county) Baltimore	
PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.	22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer		
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 9/60	22b. DATE THEREOF 2024	22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer	22d. LOCATION (City, town, or county) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip Hersey Sons Orleans St</i>	ADDRESS 2024	24a. REC'D BY REGISTRAR DATE JAN 11 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

052

CERTIFICATE OF DEATH

Reg. Dist. No.

00525

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)		c. LENGTH OF STAY IN lb 34y 1m 16d	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Route 1, Westminster, Maryland	
515		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7	
3. NAME OF DECEASED (Type or print)	First MAMIE	Middle - - -	Last ZEPP
4. DATE OF DEATH	Month 1	Day 21	Year 1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/1/93
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	58-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY The Family Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John W. Zepp	14. MOTHER'S MAIDEN NAME Unknown	Ida Heltibriddle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no. or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT	Address Springfield State Hospital Record
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic degenerative myocarditis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Schizophrenic reaction, simple type in a mental defective			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 18, 1958, to 1-21-60, 19, that I last saw the deceased alive on 1-21-, 1960, and that death occurred at 11:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Konstantin Weber		ADDRESS (Street, city or town, state) Oak Street	
PHYSICIAN'S NAME (Type) Konstantin Weber, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/24/60	
22c. NAME OF CEMETERY OR CREMATORIAL St. Bartholomew Cem.		22d. LOCATION (City, town, or county) Nr. Hanover, York Co., Pa.	
22e. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR DATE JAN 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

